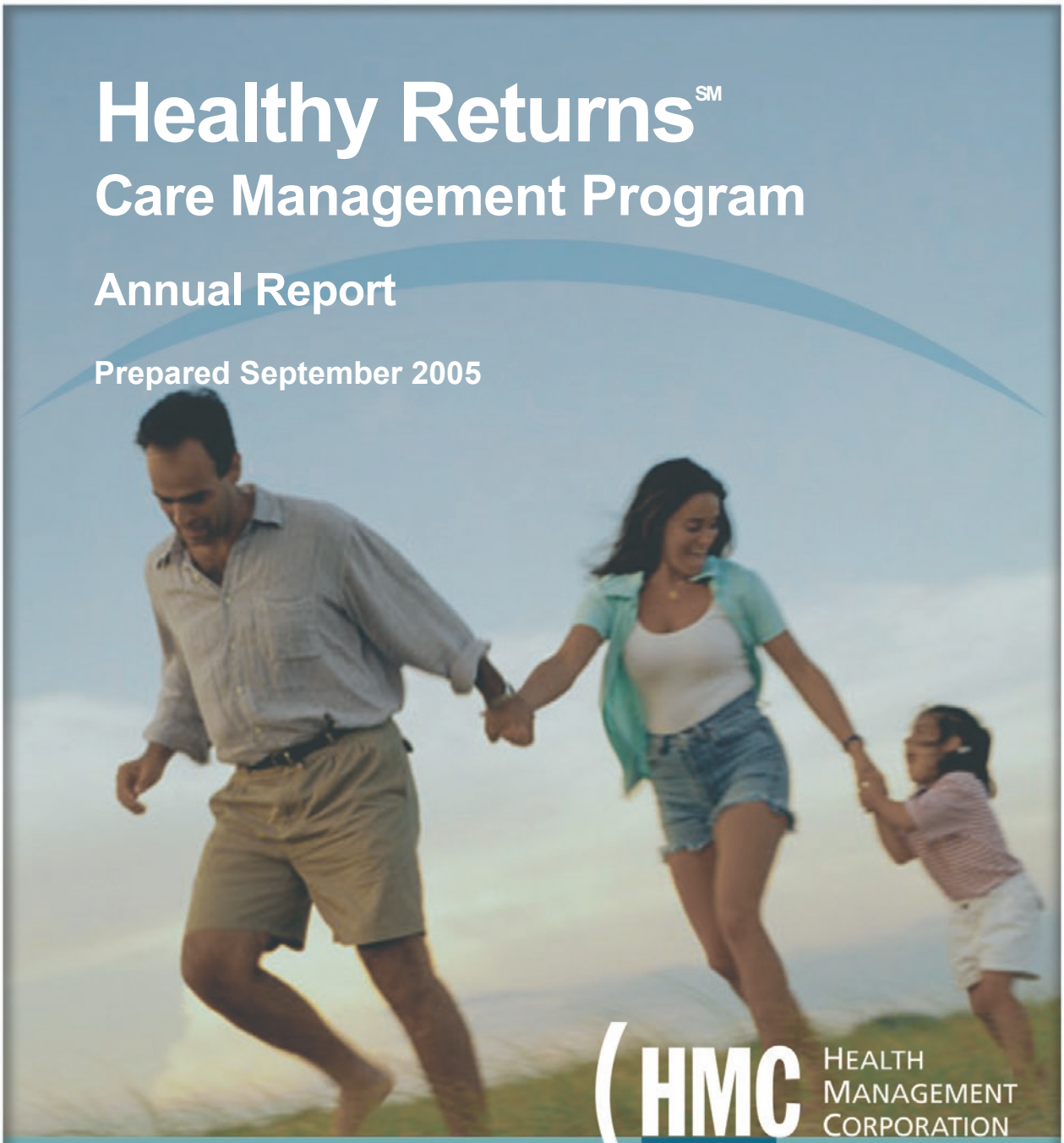
Healthy Returns℠

Care Management Program

Annual Report

Prepared September 2005



HMC Health Management Corporation

Commonwealth of Virginia

Department of Medical Assistance Services

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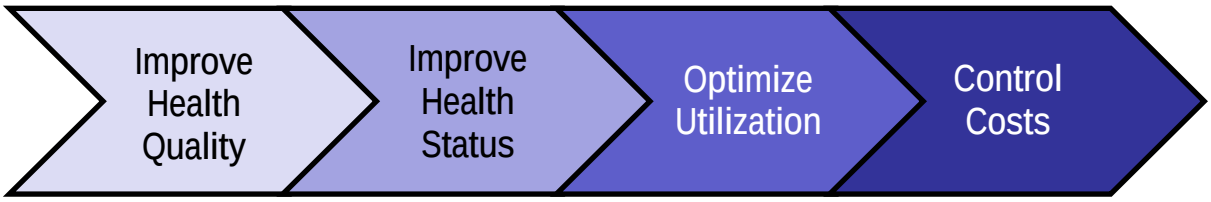
Introduction

This report is a summary of clinical and financial outcomes for the Commonwealth of Virginia Department of Medical Assistance Services (DMAS) members managed as part of the Healthy Returns℠ Care Management Program. This pilot program, implemented in June 2004, was agreed upon by DMAS, Anthem Virginia and Health Management Corporation. The pilot program is facilitated by Health Management Corporation for the management of members identified with diagnoses of coronary artery disease (CAD) and congestive heart failure (CHF).

The Healthy Returns Care Management Program fosters improved health of its managed members by better coordinating physician services and patient self-care, emphasizing increased adherence to behaviors associated with optimal health and pharmacy guidelines. Specifically, the program strives to:

- Improve health quality outcomes
  - Reflected in people having the right tests performed in compliance with recommended guidelines
- Improve health status outcomes
  - Reflected in people having improved clinical test levels and fewer days of lost activity
- Optimize utilization
  - Improvement in health outcomes optimizes utilization of medical services – use of preventive services drives reductions in use of expensive medical services, such as inpatient admissions and emergency room visits
- Control healthcare costs
  - Control costs due to improved process, status and utilization outcomes



Claims-based outcomes, utilization and financial analysis are reported for the following time periods:

Baseline: June 1, 2003 through March 31, 2004, with claims paid through June 30, 2004.
Year 1[1]: June 1, 2004 through March 31, 2005 with claims paid through June 30, 2005.

Please note the time periods analyzed are not a typical 12-month period, but shortened to 10 months so the initial program results could be provided to DMAS in the time requested. It is prudent to document that the shortened time frame affects the report results in two ways: 1) prevents comparison of a full 12 months of data between the Baseline and Year 1 periods, 2) analyzing 10 months of management actually translates to 8 months of activity, given the fact that the first two months following implementation are centered on member engagement and enrollment. After this initial engagement process, education and interventions are the main focus for nurse consultants. Detail on report methodology is provided in the Appendix.

[1] Throughout the report HMC will apply the label 'Year 1' to refer to the first 10 months of program management. HMC recognizes the report does not cover the entire 12 months of the first year.

Executive Summary

The Healthy Returns℠ Care Management Program has had a positive impact on clinical, utilization and financial results. Improvements in health quality and health status outcomes, as well as better utilization of services, resulted in a gross savings of $23.15 per diagnosed member per month (PDMPM) for Year 1 compared to Baseline. Utilization related to the conditions managed also improved. As DMAS members continue to be educated on better health care practices and realize more appropriate use of services, it is expected they will continue the trend toward targeted clinical levels and overall improved health.

Clinical / Health Quality Improvements

Members improved results in 9 of 12 clinical outcomes. During the first year of management, improvements were made among self-care practices as well as testing rates and status scores. The following are highlights of clinical outcomes:

- Members with CAD reported compliance with cardiac-related medications, including daily aspirin/anti-platelet therapy and beta blockers; improved LDL scores and healthy blood pressures were also reported.
- Significant improvement was observed for the following self-reported measures: daily weight monitoring for CHF members and daily anti-platelet therapy for members with CAD.
- Based on claims review, the rate of LDL testing increased for members with CAD and CHF.
- Members with CHF reported improvements in self-care practices including blood pressure control, adherence to a sodium restricted diet and monitoring daily weight. Based on claims results, rates of ACE inhibitor use and beta blockers declined. While the members' status is improving, nurse consultants and pharmacists will continue their focus on appropriate drug regimens for treatment of CHF.

Health Status Improvements

- Among members with at least two nurse assessments and reporting results:
    - 94% of CAD members report LDL values of less than 100, up from 84%. This is excellent and indicates improved condition management.
    - 26% improvement among assessed CHF members who reported blood pressure below the target level of 130/85 mm/Hg.
    - 76% of assessed CAD members reached their target blood pressure, a 6% improvement.
    - For CAD members who have diabetes as a comorbid, the percentage of compliant members declined 14%. This finding indicates members are not managing their diabetes as necessary. The management of diabetes and cardiac conditions is closely related; therefore it is important that both conditions receive appropriate treatment. If either condition is uncontrolled, it may adversely affect the comorbid condition, leading to various complications and possible hospital stays.
- According to results of the SF-12® Health Survey, members reported their mental functioning improved 13% across both conditions while physical functioning was stable. This is very positive as it indicates willingness for change and perceived ability to make lifestyle changes. Fifty-one percent of members reported improved physical scores, while 68% reported an improvement in their mental function scores.
- Average days of lost activity declined for members with CAD but increased for members with CHF. The program goal is to reduce days of lost activity to less than 4 days by improving overall mental and physical health status. Nurse Consultants continue to work with all managed cases to address limitations related to their condition, such as having a sick day plan, in order to minimize negative impact on the member's quality of life.

Utilization of Services Optimized

The Healthy Returns Care Management Program seeks to optimize utilization by reducing expensive exacerbations of care while encouraging drug regimen adherence and preventive care.

- Among inpatient measures, admissions per 1,000 were down 5%, driven by decreases in CHF-related admissions. Similarly, days per 1,000 declined 11%, driven by CHF-related declines.
- Consistent with program management, there was increased utilization among professional related visits. Specifically, outpatient facility utilization rose 5% and outpatient professional utilization increased 23%. These findings are positive as they are consistent with program goals to reduce acute care and increase routine care.
- The overall rate of filled prescriptions increased 3% from Baseline to Year 1. An increase in pharmacy utilization is expected as nurse consultants and pharmacists educate members about appropriate drug regimens for their conditions. Specifically, there was improvement among cardiac-related medications. The use of lipotropics and beta blocking agents both increased in Year 1.
- Another positive effect of condition-related education is that utilization of some drug classes may decrease as interventions identify inappropriate medications or contraindications. This is evident in declines observed for the following drug classes: quinolones, non-sedative barbiturates, various analgesics and antihistamines.
- In an effort to promote appropriate pharmacy utilization, HMC suggests the implementation of pharmacy alerts, which include mailings and notices sent to providers that alert the physician to contraindications or that the member has no prescription for a specific drug or has not filled their prescription.

Costs Controlled

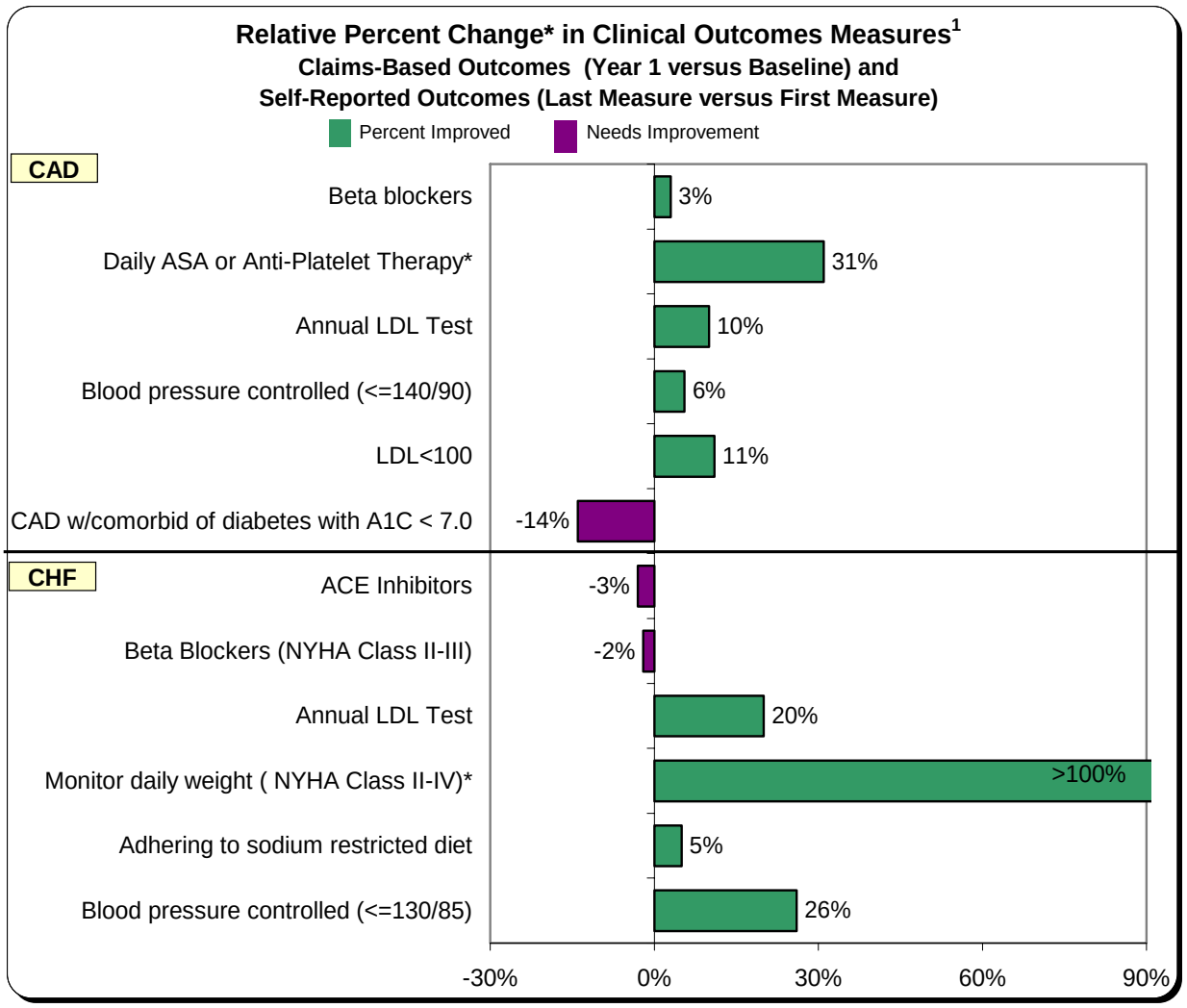
As members with chronic conditions improve their health status and adherence to guidelines, the result is optimized utilization of services. As utilization patterns change in a positive manner, costs can be more effectively controlled.

- Expense per Diagnosed Member per Month (PDMPM) decreased $23 between Baseline and Year 1 (from $1248 to $1225), leading to a 2% gross savings rate. Baseline expense was trend-adjusted using general population cost trends from Richmond Medicaid. Utilization trends were not applied.
- Due to the fact that no fees were incurred by DMAS for this pilot cardiac program, HMC did not provide a return on investment calculation, but rather presents gross savings. HMC believes this provides the most accurate interpretation of savings for the period analyzed.
- The overall savings was driven by a decline in pharmacy expense ($17 PDMPM) as total medical expense decreased $6 PDMPM, driven by non-condition-related expense. While the overall results are positive and improvements were made, the fact that non-condition-related expense drove the savings indicates there is much room for improvement to successfully manage these conditions.
- Across all settings, there were improvements in expense for diagnoses related to program managed conditions:
    - For ‘other forms of heart disease’, there was a 9% decline PDMPM expense.
    - Expense related to hypertensive disease declined 15%.

In summary, program results indicate that the Healthy Returns Care Management Program is making strides in improving the health of DMAS members in the pilot program. As the pilot program expands to include members with asthma, diabetes and chronic obstructive pulmonary disorder, the DMAS population will continue to experience improved outcomes and health status. Additional opportunities for enhancing program value are outlined in the Program Initiatives and Strategies section of the report. Health Management Corporation and Anthem Virginia look forward to continued collaboration with DMAS.

Overall Outcomes Summary

This section provides an overview of the clinical outcomes for members with CAD and CHF. Outcomes are either self-reported (reported by the member during the telephonic condition assessment) or based on claims review. Results are illustrated by condition for percent improvement (below) and a comparison of Baseline to Year 1 (see following pages).

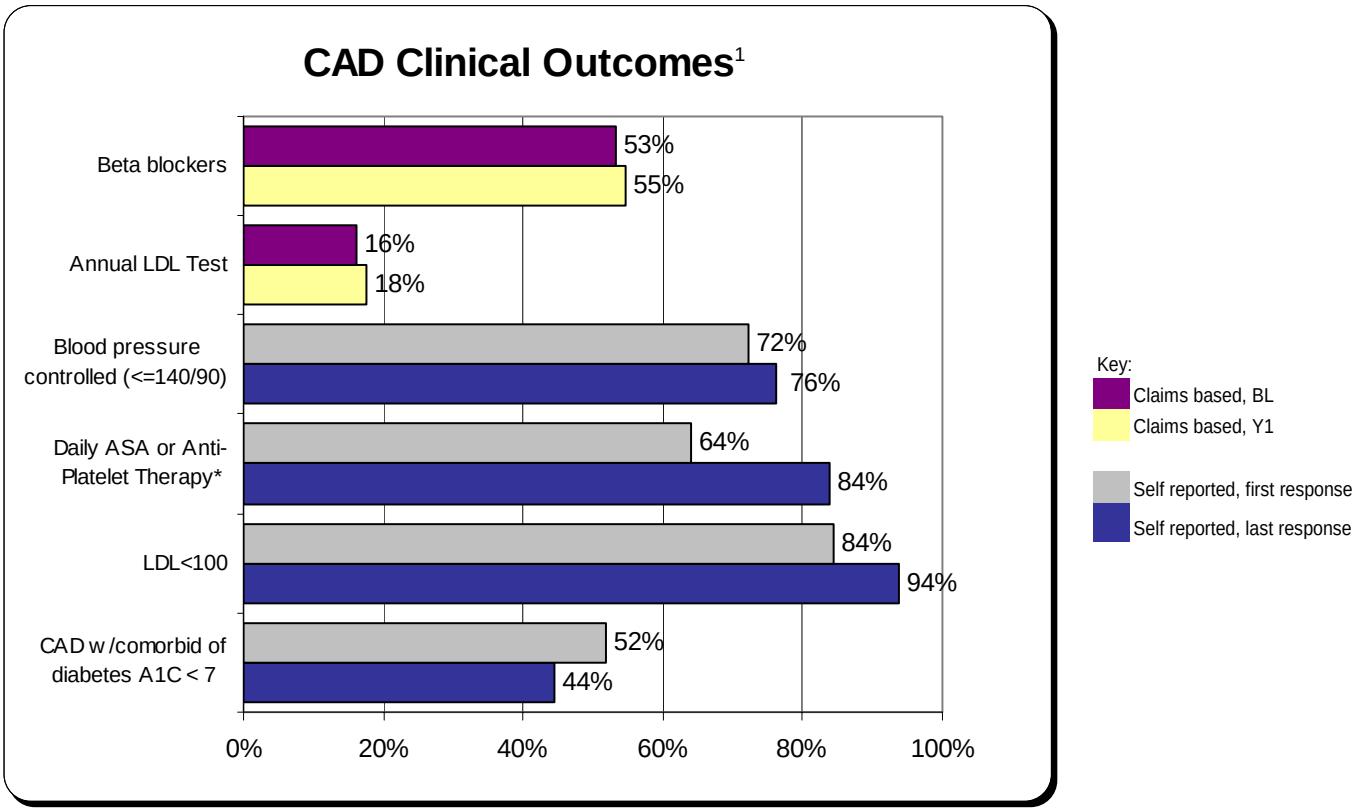


[1] Evaluation Period for claims-based measures is Baseline versus Year 1; for self-reported measures, the evaluation period is most recent assessment measure versus first assessment measure.

* Percent change for self-reported outcomes is considered statistically significant at the 0.05 level using a two-tailed test. Statistical comparisons between claims-based outcomes cannot be made due to the fact that Baseline and Year 1 populations are partially overlapping.

- Members improved results for 9 of 12 clinical outcomes. Significant improvement was observed for the following self-reported measures: daily weight monitoring for CHF members and daily anti-platelet therapy for members with a primary condition of CAD.
- Testing rates for annual LDL screenings improved for members with CAD and CHF. Likewise, persons maintaining healthy blood pressures improved across both cardiac conditions.
- There was a notable 11% increase among members with CAD who reported LDL values below 100.
- Members with CHF reported improvements in self-care practices including blood pressure control, adherence to a sodium restricted diet and monitoring daily weight. Based on claims results, rates of ACE inhibitor use and beta blockers declined slightly. While the members' status is improving, nurse consultants and pharmacists will continue their focus on appropriate drug regimens for treatment of CHF.

CAD Health Quality and Health Status Outcomes

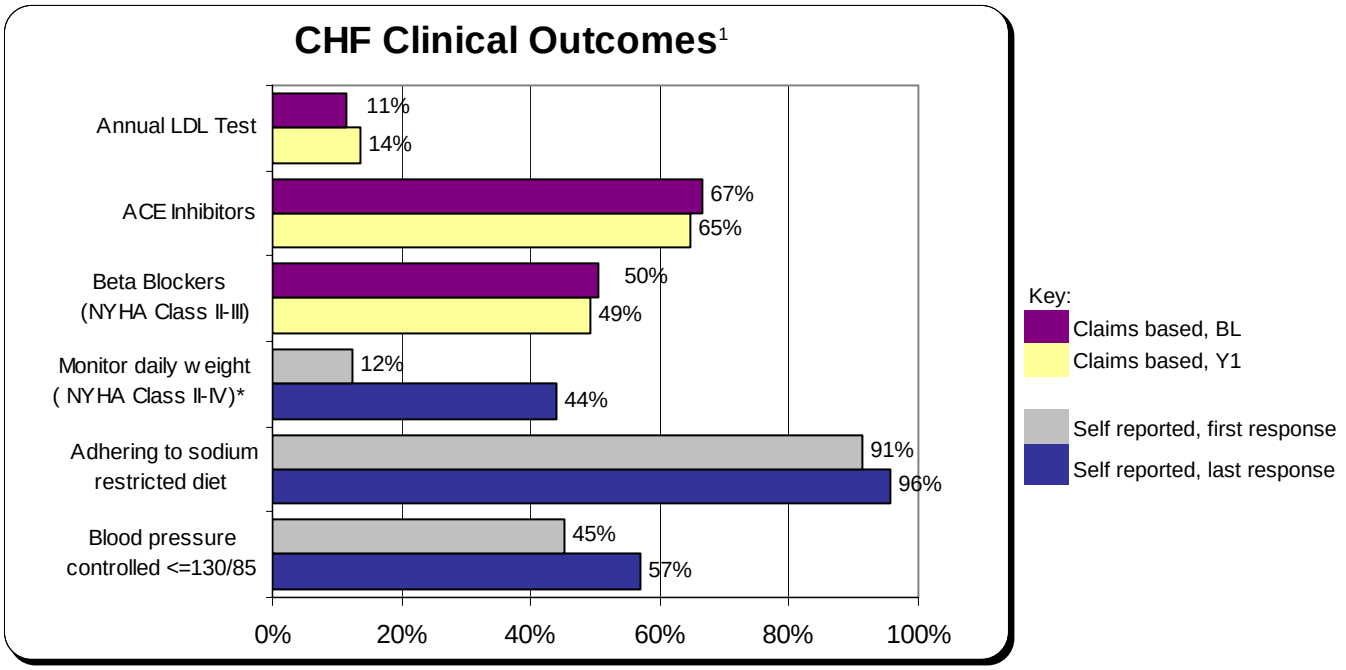


[1] Evaluation Period for claims-based measures is Baseline period versus program Year 1; for self-reported measures, the evaluation period is most recent assessment measure versus first assessment measure.

* Percent change for self-reported outcomes is considered statistically significant at the 0.05 level using a two-tailed test. Statistical comparisons between claims-based outcomes cannot be made due to the fact that Baseline and Year 1 populations are partially overlapping.

- Members with CAD improved or maintained 5 of the 6 clinical outcome measures from baseline or first measure; one measure declined—for members with diabetes as a comorbid, the percentage of members with an A1C score less than 7 declined from 52% to 44%. As management of diabetes improves, the percent of members achieving this target should increase.
- Member status results were very positive as improvements were reported for blood pressure, LDL levels and daily anti-platelet therapy.
- Significant improvement was reported for daily anti-platelet therapy with 84% of assessed members achieving the goal, up from 64% at first measure.

CHF Health Quality and Health Status Outcomes



[1] Evaluation Period for claims-based measures is Baseline period versus program Year 1; for self-reported measures, the evaluation period is most recent assessment measure versus first assessment measure.

* Percent change for self-reported outcomes is considered statistically significant at the 0.05 level using a two-tailed test. Statistical comparisons between claims-based outcomes cannot be made due to the fact that Baseline and Year 1 populations are partially overlapping.

- Members with CHF made improvements in four of six clinical outcome measures, including:
  - Members reported a significant improvement in daily weight monitoring, in which monitoring increased from 12% to 44% of assessed members.
  - Members with healthy blood pressures increased, where 57% of assessed members have attained compliance (up from 45%).
  - The majority of CHF members (96%) report adherence to a sodium restricted diet; this measure continues to improve.
- There was a slight decrease in pharmacy utilization as prescriptions for ACE inhibitors and Beta blockers declined.
- Similar to members with CAD, LDL testing rates increased for CHF members, from 11% to 14%. This finding is very positive as results for LDL screening is critical for proper management of cardiac conditions.

Health Status Outcomes

In addition to clinical measures, member-specific intervention plans are developed to address members' behaviors and lifestyle, factors that indirectly and directly impact health quality and status. These factors include quality of life/self-perception and days of lost activity.

One of the important management tools used by HMC is the SF-12® Health Survey, a twelve-question survey used to monitor the member's perception of their mental and physical function. The results provide an indication of the member's readiness for change[2]. This questionnaire is administered to all high intensity members during the initial assessment, and annually thereafter. The results below are for members with two completed surveys.

SF-12 Survey Scores
First Measure vs. Last Measure for Reassessed Members

		Mental Component				Physical Component			
Cond	Number of Responses	Avg First	Avg Last	Relative Improvement	Significant Change*	Avg First	Avg Last	Relative Improvement	Significant Change*
CAD	105	39.5	44.9	14%	No	29.3	28.9	-1%	No
CHF	55	40.3	44.9	11%	Yes	28.8	29.9	4%	No
TOTAL	**160**	**39.8**	**44.9**	**13%**	**No**	**29.1**	**29.3**	**1%**	**No**

* Indicates change from first to last measure is significant at the 0.05 level using a two-tailed t test.

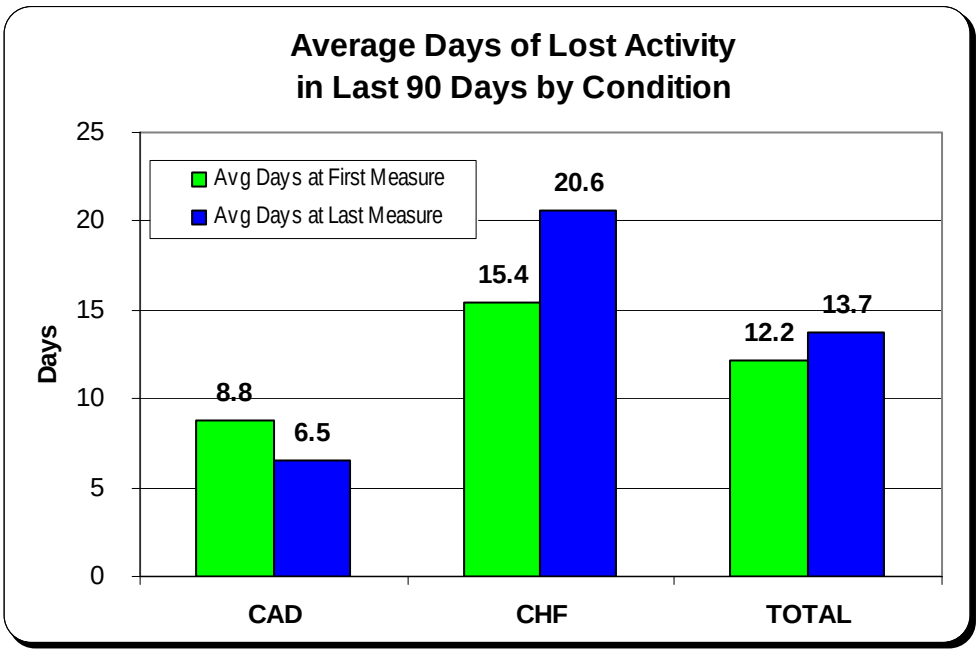
Note: The SF-12® scores represent the member's self-perception of his/her physical and mental ability. This questionnaire is administered to all high intensity members during the initial health assessment and at least annually thereafter.

- There was a notable improvement within the mental component for both conditions while physical functioning remained stable. Across all conditions, there was a 13% relative improvement in mental function and 1% improvement for physical function.
- The average scores for this population are improving but remain below national norms (50).
- Scores for the mental component significantly increased for members with CHF.
- Overall, 68% of assessed members reported improvements in mental functioning, while 51% reported improvements in physical functioning.

Improvement from First Measure	n =	# Improved	% Improved
Improved Mental Functioning	160	108	68%
Improved Physical Functioning	160	81	51%

[2] Ware, J.E., Jr., Kosinski, M., Keller SD. *SF-12® How to Score the SF-12® Physical and Mental Health Summary Scales.* Lincoln, RI: QualityMetric Incorporated, Third Edition, April 2000.

Another key measure tracked by HMC is 'Days of Lost Activity'. Days of lost activity are an important measure of health status used to gauge how the program impacts the members' quality of life. Members are asked to recount how many days during the last three months their condition limited or prevented their normal activities, such as going to work, school or social activities.



Condition	n =	Avg Days Lost		Goal[1]	Significant Change[2]
		First	Last		
CAD	23	8.8	6.5	< 4.0	N/A
CHF	24	15.4	20.6	< 6.0	N/A
All Conditions	**47**	**12.2**	**13.7**	**< 4.0**	No

[1]Goal Source: Foundation of Accountability

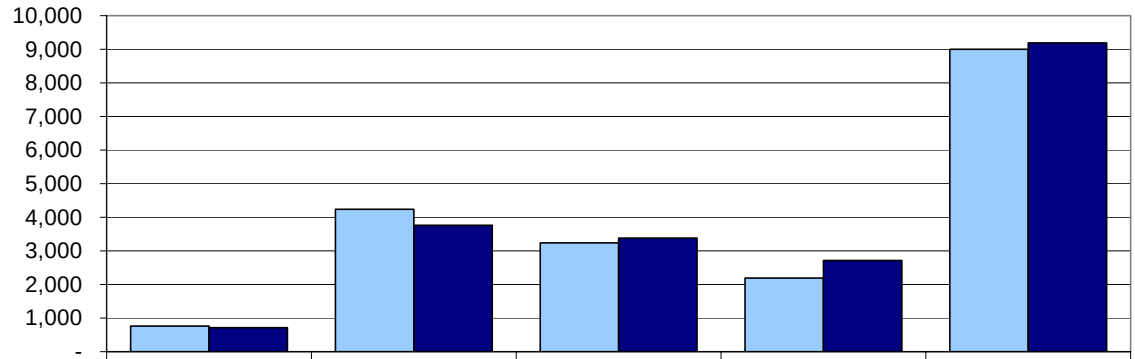
[2]The difference between the first and last measures is considered statistically significant at the 0.05 level using a two-tailed paired t-test. Significance testing is not recommended for samples <30.

- Overall, days of lost activity increased 12% between first and last measure among assessed members, driven by an increase in average days of lost activity for CHF members.
- Members with CAD did have an improvement, falling from 8.8 days to 6.5 days. However, the average remains above the target of less than 4 days.
- Nurse Consultants continue to work with all managed cases to address limitations related to their condition, such as having a sick day plan, in order to minimize negative impact on the member's quality of life.

Overall Claims Utilization Summary

A major goal of the Healthy Returns Care Management Program is to optimize utilization by decreasing acute care in a hospital setting, while increasing preventive care via outpatient professional visits and medication compliance. Please note that utilization and expense cover a 10-month time period rather than the preferred 12-month time period.

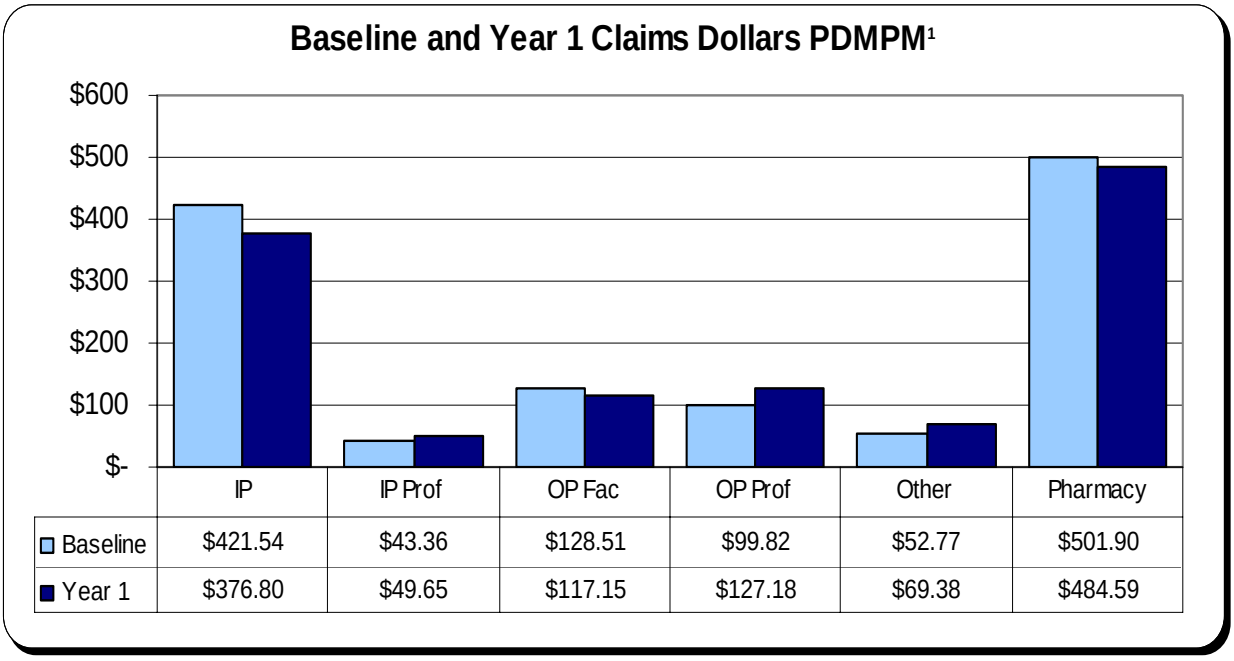
Baseline and Year 1 Utilization
per 1,000 Member Months
(per 100 Member Months for OP Prof and Pharmacy)



	IP Adm	IP Days	OP Fac Visits	OP Prof Visits	Pharmacy
Baseline	752	4,215	3,234	2,213	8,977
Year 1	715	3,765	3,390	2,727	9,205

- Among inpatient measures, admissions per 1,000 were down 5%, driven by decreases in CHF-related admissions. Similarly, days per 1,000 declined 6%, driven by CHF-related declines.
- Consistent with program management, there was increased utilization among professional related visits. Specifically, outpatient facility utilization rose 5% and professional visits increased 23%. These findings are very positive, as they are consistent with the program goals to reduce acute care and increase routine, planned care.
- The overall rate of prescriptions filled increased 3% from Baseline to Year 1. An increase in pharmacy prescriptions is expected as nurse consultants and pharmacists educate members about appropriate drug regimens for their conditions and identify inappropriate medications or contraindications. As a result, utilization for cardiac-related drugs may increase as others decline. This is evident in the 12% increase in lipotropics but an 11% decline in quinolones (class of antibiotics) and 13% decline in antihistamines.
- Based on filled prescriptions, there was improvement among cardiac-related medications. The use of lipotropics and beta blocking agents both increased in Year 1 while calcium channel blocking agents were stagnant and ACE inhibitors declined just 4%.

Overall Claims Expense Summary

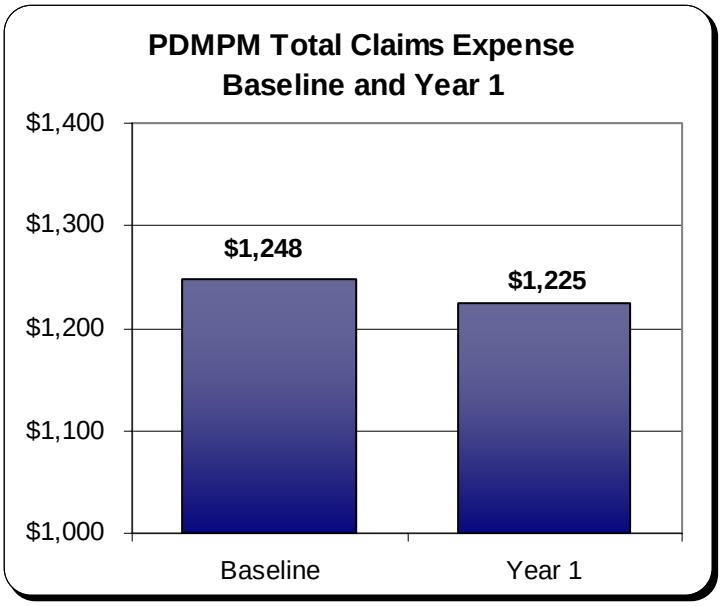


	IP	IP Prof	OP Fac	OP Prof	Other	Pharmacy
Baseline	$421.54	$43.36	$128.51	$99.82	$52.77	$501.90
Year 1	$376.80	$49.65	$117.15	$127.18	$69.38	$484.59

[1] Baseline medical and pharmacy expense has been trend-adjusted. Source: Anthem Actuarial.

- For DMAS members, total expense PDMPM decreased 2% in Year 1 when compared to Baseline. This decrease was driven by notable declines in inpatient and pharmacy expense.
- There was an 11% decline in inpatient expense, consistent with program goals. However, declines in expense were driven by non-condition related hospital stays, indicating there is much room for progress in order for members to gain control of their cardiac conditions. (Please refer to Table 3 in the Appendix.)
- Consistent with utilization patterns, PDMPM expense for outpatient professional and other settings increased.
- Total pharmacy expense declined 3%. While a decline in pharmacy expense is atypical, it is consistent with the utilization patterns. Similarly, as cardiac-related drug utilization increased, there was an increase in cardiac-related expense, led by a 21% increase in expense for lipotropics. (Please refer to Table 2 in the Appendix.)

Financial Summary



DMAS Program Savings				
Program Time Period		Baseline		Year One
Diagnosed Member months		27,581		26,734
Costs (total)				
Medical claims expense	$	20,575,296	$	19,787,241
Rx claims expense	$	13,842,984	$	12,955,071
Total Claims Expense	$	34,418,280	$	32,742,312
Total Expense PDMPM	$	1,247.90	$	1,224.74
Gross savings			$	618,998
Gross savings (PDMPM)			$	23.15
Savings Rate (Gross Savings PDMPM/Trended BL PDMPM)				1.86%
Baseline expense was trend-adjusted. Source: Anthem Virginia Actuarial Department				

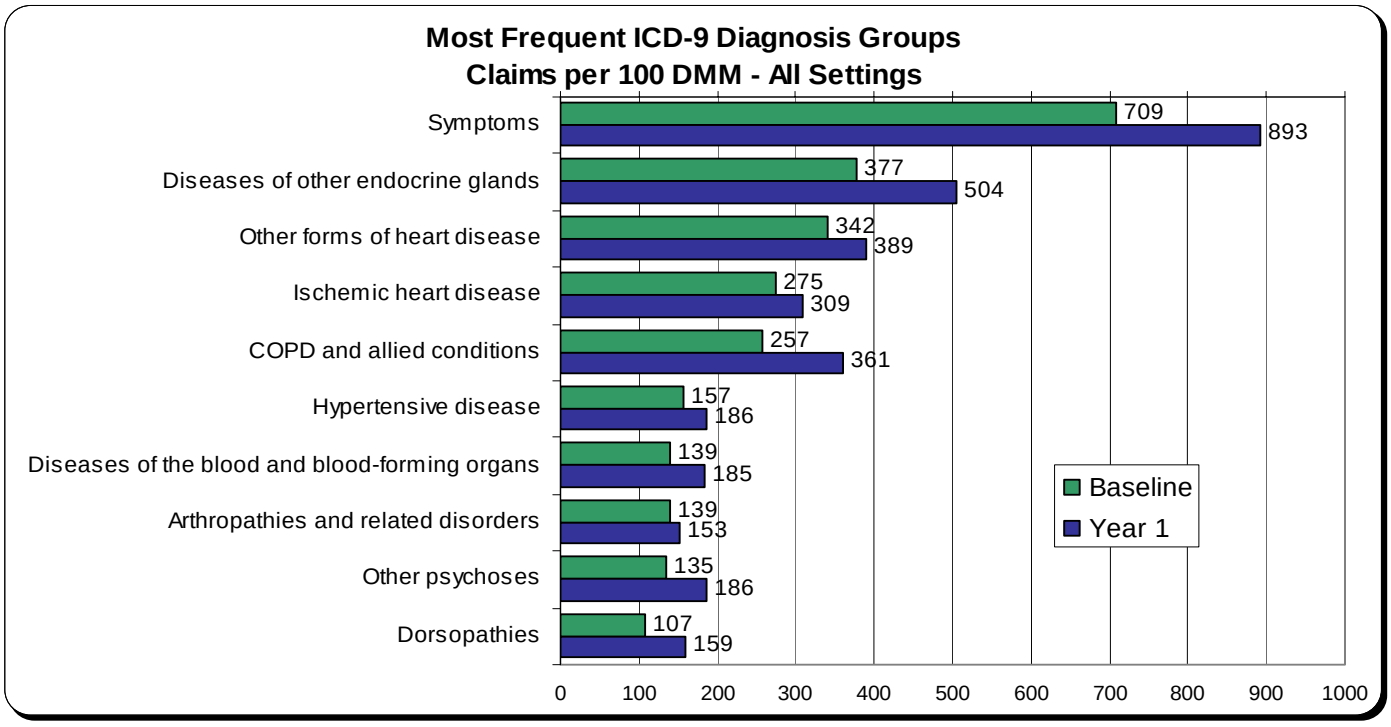
Note: HMC and DMAS agreed to apply Richmond Medicaid trends to the DMAS baseline claims because DMAS was unable to provide the requisite trend information. Trends for Richmond Medicaid are based on the general Richmond Medicaid population and calculated by Anthem Actuarial Department.

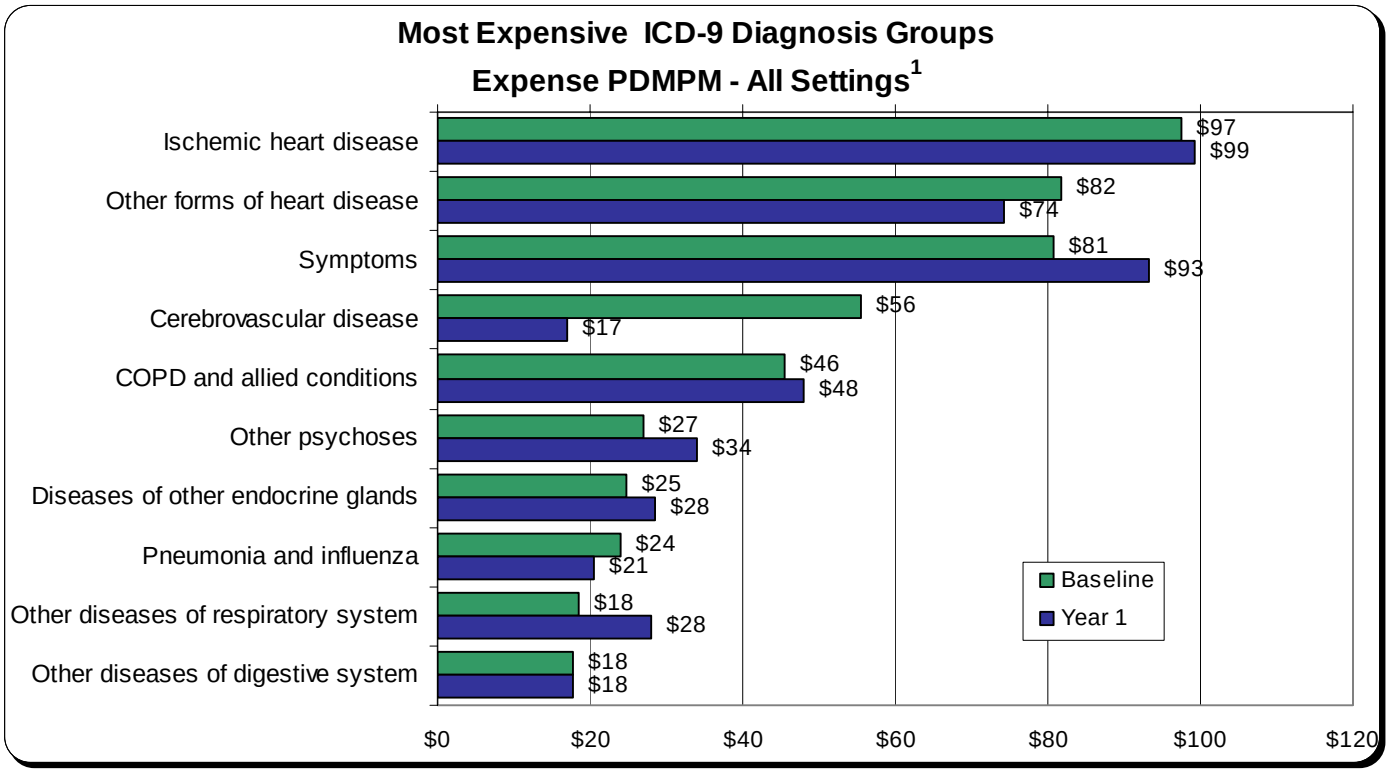
- Following the positive utilization and financial outcomes, DMAS experienced $23.15 gross savings per diagnosed member per month (PDMPM).
- The reduction in total claims expense from $1248 to $1225 represents a gross savings rate of 1.86%.
- Due to the fact that no fees were incurred by DMAS for this pilot cardiac program, HMC did not provide a return on investment calculation, but rather presents gross savings. HMC believes this provides the most accurate interpretation of savings for the period.

Claims Utilization Summary

The following sections of the report provide further analysis related to claims utilization and expense for drug classes as well as ICD-9 diagnosis category for multiple treatment settings. This analysis serves to support and further explain the findings presented earlier in the report.

Top 10 Medical Diagnoses

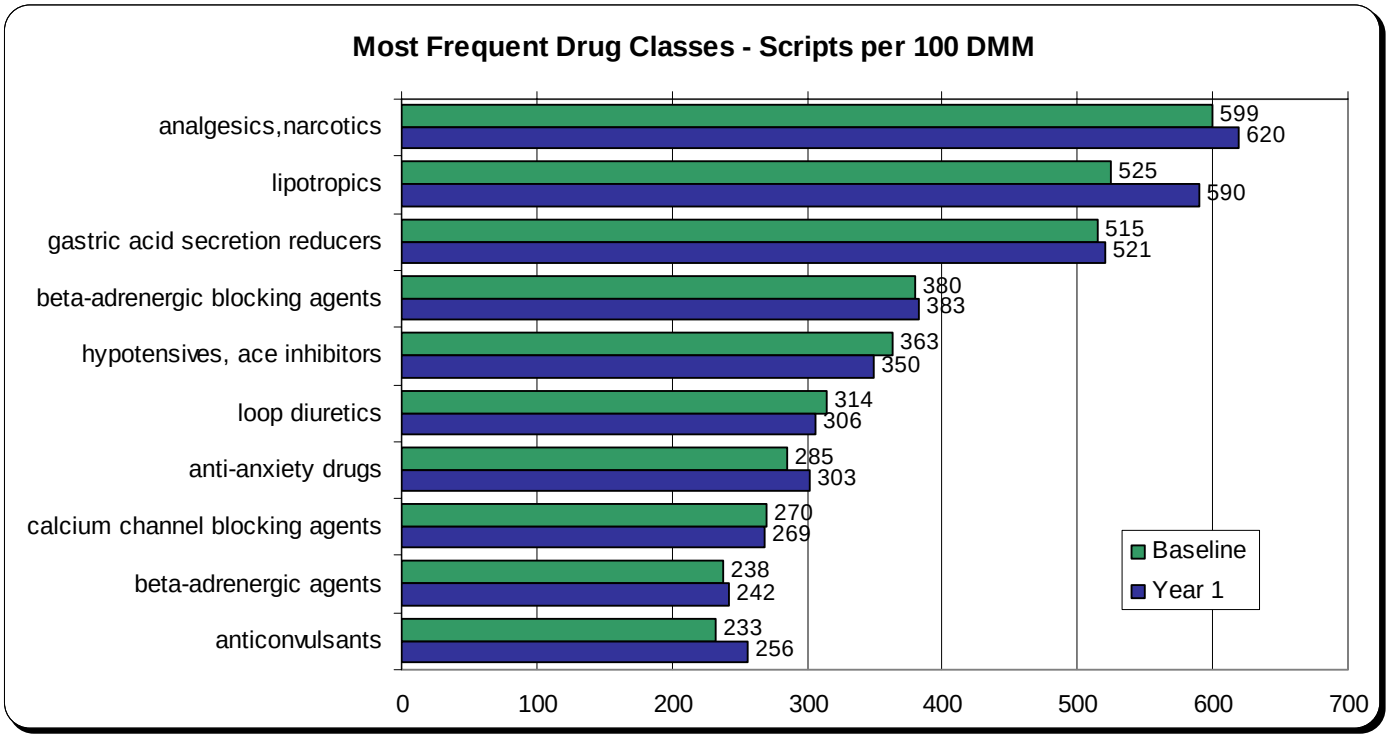


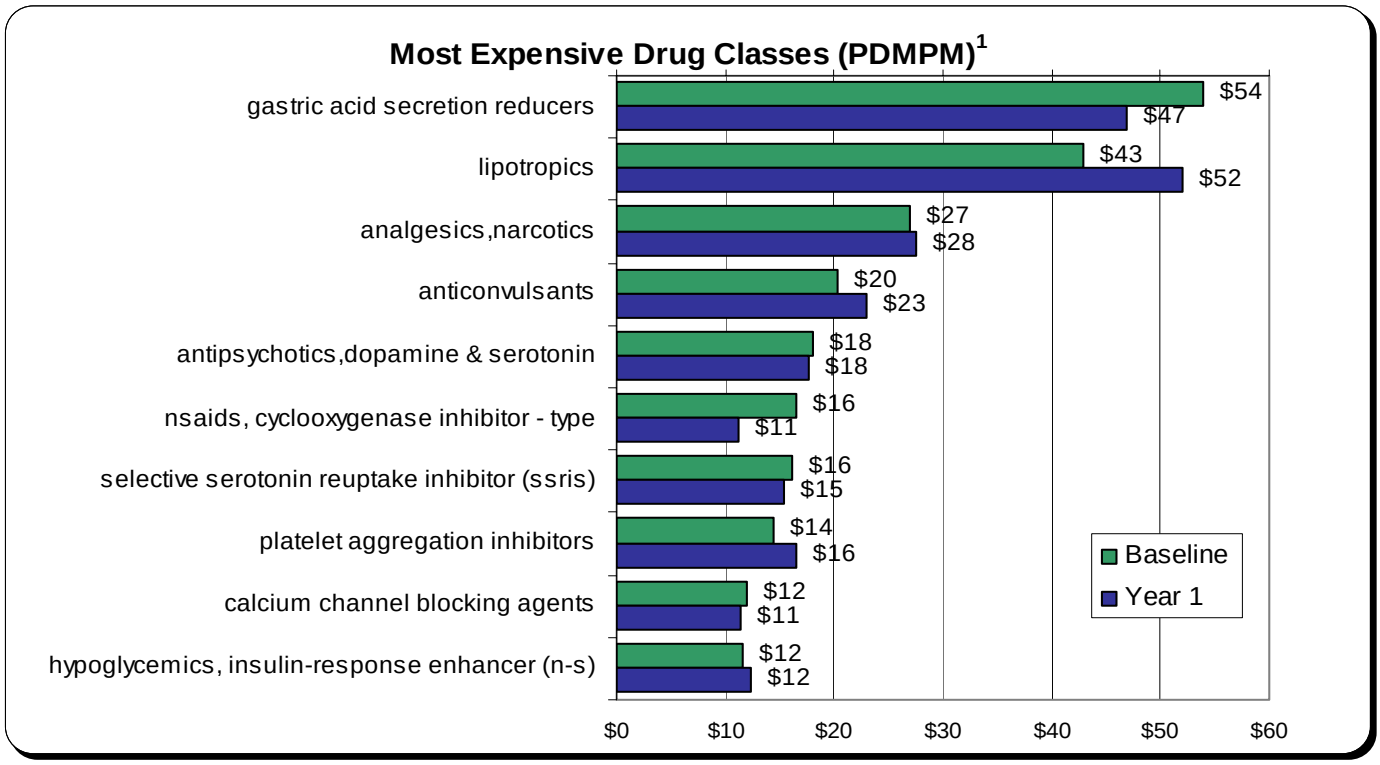


[1] Expense for Baseline has been trend-adjusted.

- On the previous page, the most frequent ICD-9 diagnosis classification is Symptoms (includes diagnoses such as abdominal pain, chest pain, nausea etc.), which is typical since this looks at diagnoses across all treatment settings including emergency room visits.
- The second most frequent class is 'Diseases of other endocrine glands' followed by 'Other forms of heart disease' and 'Ischemic heart disease'. This is expected given the DMAS population includes cardiac members only and diabetes is a common comorbid of CAD and CHF.
- As found in most populations, 'Ischemic heart disease' is the most expensive diagnostic category, followed by other forms of heart disease.
- As reported earlier in the report, savings was driven by non-condition related expense. This finding is reiterated here as there was a 2% expense increase in 'Ischemic heart disease'. (Please refer to Table 1 in the Appendix.)
- However, other categories of cardiac-related expense, such as 'Other forms of heart disease' and 'Cerebrovascular disease' reported notable declines, 9% and 69%, respectively.

Top 10 Pharmacy





[1] Baseline expense has been trend-adjusted.

- Analgesics, narcotics were the most frequently prescribed medication class, while gastric acid secretion reducers were the most expensive drug class. This finding is atypical and indicates that pain management is a significant consideration in providing care management to this population. Nurse consultants and pharmacists will consider the potential impact these drugs may have with cardiac-specific medications and target their interventions appropriately to reduce adverse side effects or contraindications.
- In Year 1, lipotropics accounted for 11% of total pharmacy expense while gastric acid secretion reducers accounted for 10% of total pharmacy expense.
- One of the program targets is to collaborate with members and physicians to ensure members are taking appropriate medications as prescribed. A positive finding is that cardiac-related medications, including lipotropics, beta blockers and ACE inhibitors were all represented in the top 10 most frequently prescribed medications. The presence of a large number of cardiac-related medications on the most expensive and frequent drug classes is expected as the program seeks to achieve appropriate medication compliance among members. (Please refer to Table 2 in the Appendix.)

Membership and Activity Profile

Member Identification and Risk Stratification

As of March 31, 2005, 3,251 cases have been identified for participation in the Healthy Returns program.

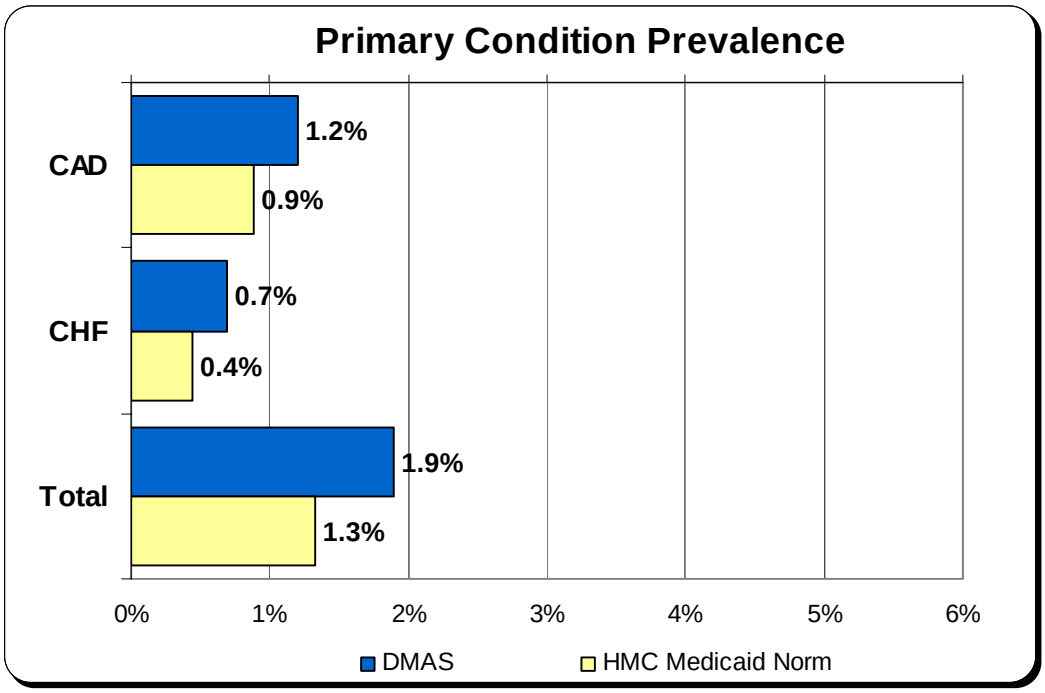
- Approximately 61% of these members have CAD as their primary condition, followed by 39% with CHF. This distribution cannot be compared with other managed populations because the pilot is limited to two conditions rather than the standard suite of conditions: asthma, CAD, CHF, COPD and diabetes.

- Of the total identified members, 31% were stratified for high intensity management. This percentage appears high but is not comparable to program norms since only cardiac conditions are involved. Given the severity of cardiac chronic disease, it is expected that the percentage of members stratified for high intensity is high.

- Based on claims analysis and assessments by the nurse consultants, members may move along the risk continuum, between standard and high intensity management, as protocols indicate.

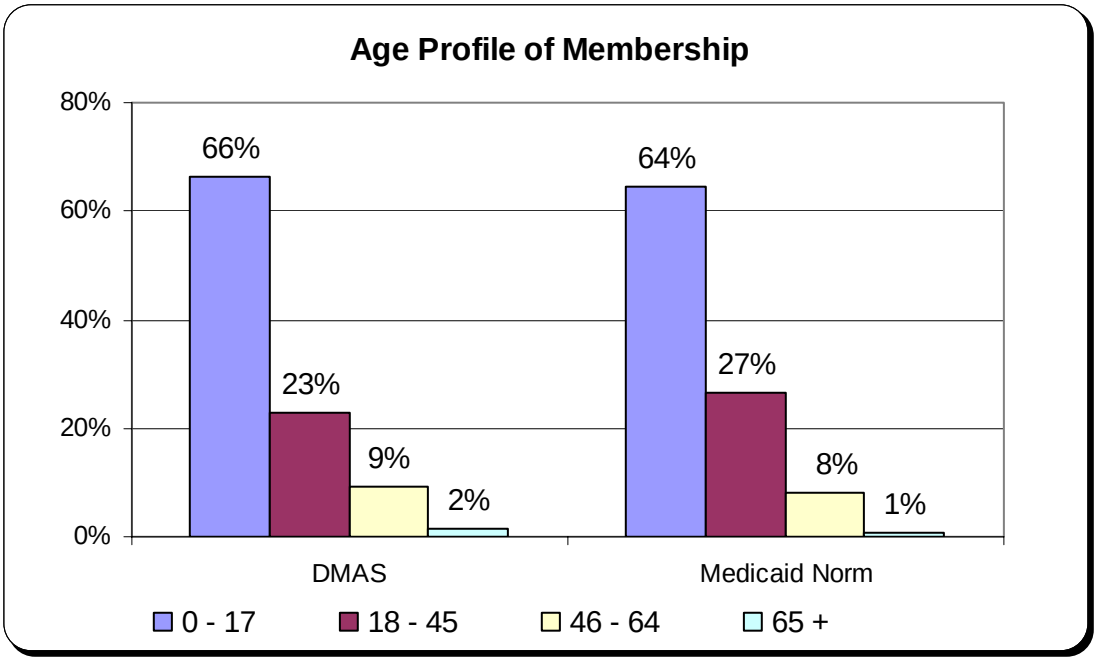
Intensity	CAD	CHF	TOTAL
High	589	422	1,011
Standard	1,388	852	2,240
Total	**1,977**	**1,274**	**3,251**

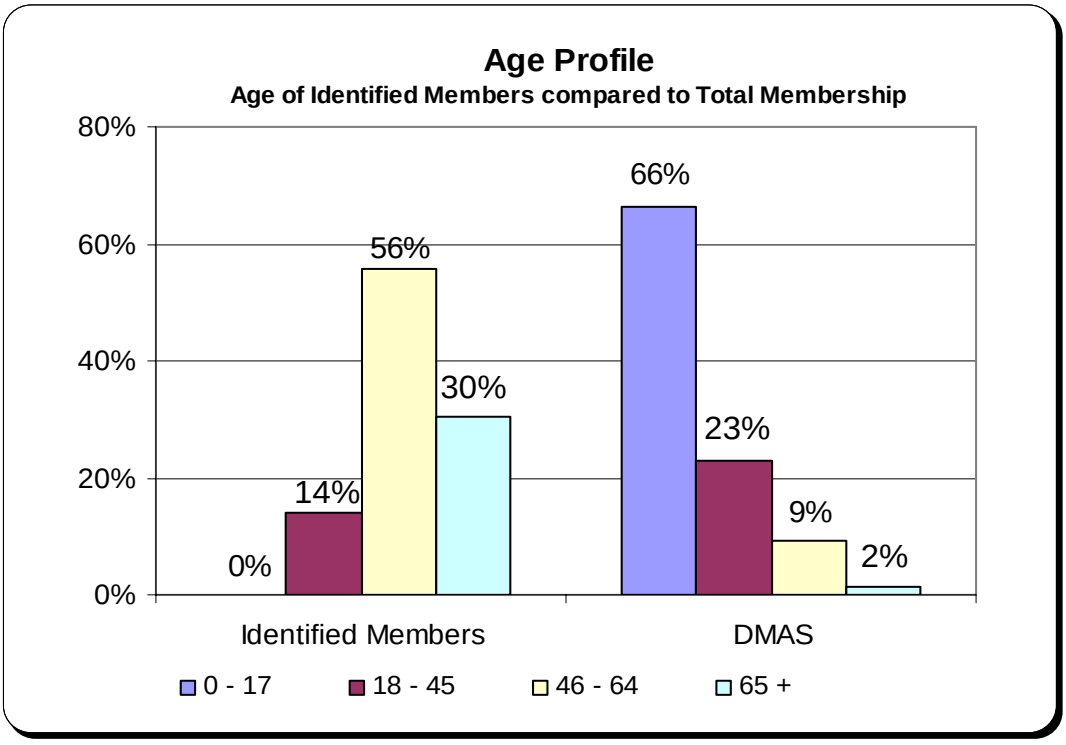
Prevalence and Age Profile



Note: Prevalence is calculated based on managed cases (non-closed cases) divided by active membership.

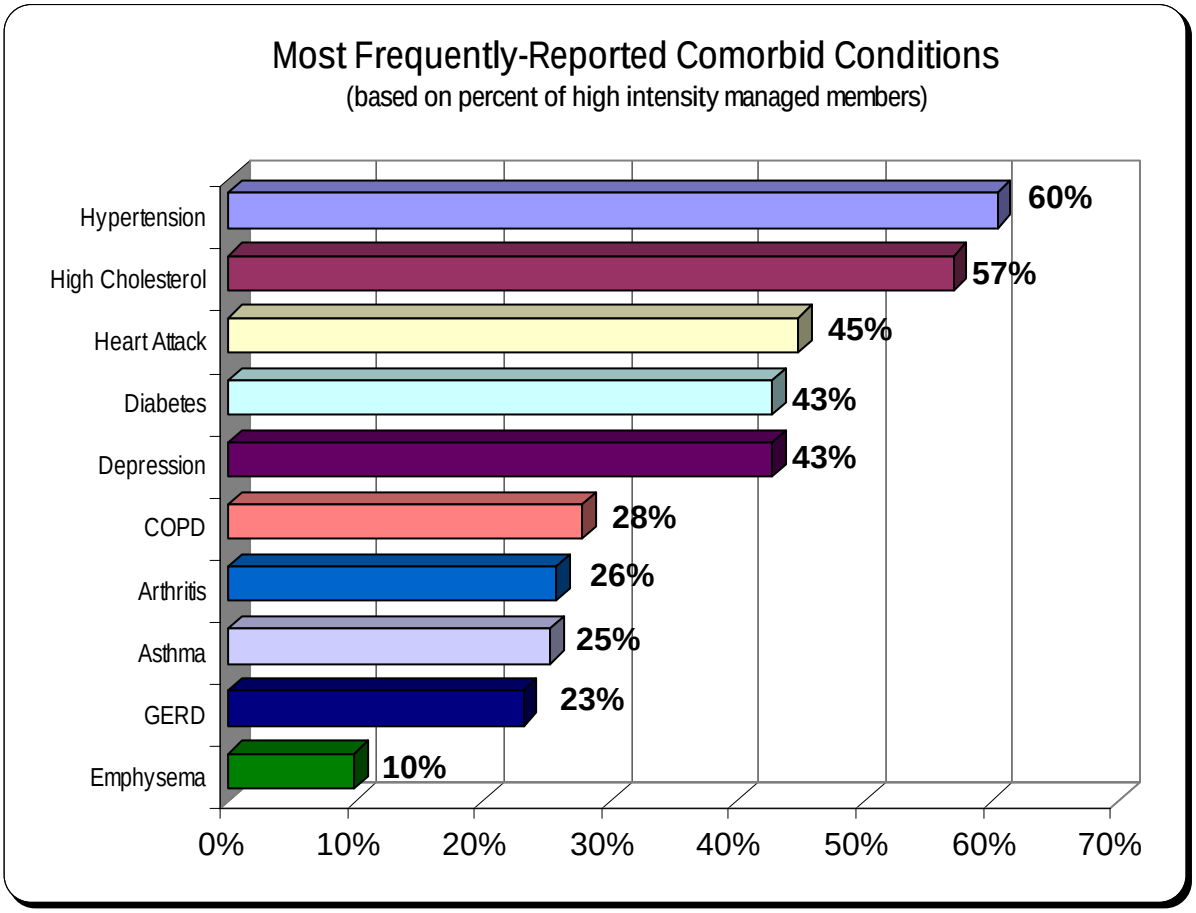
- The prevalence for both conditions among DMAS eligible members totals 1.9%, above the HMC reference population (1.3%) for the cardiac conditions.





- The average prevalence is related to the age of the eligible membership within DMAS. Overall, the age of the eligible DMAS membership is relatively consistent with the reference population. The percentage of DMAS members over age 45 (11%) is just slightly greater than the reference population (9%).
- The second graph above compares the age of identified cases to the total DMAS eligible membership. The graph illustrates that the majority of identified cases (56%) are between age 46 and 64 while just 9% of all DMAS members fall in this age category. This is expected since cardiac conditions, such as heart disease, often manifest in persons over age 50.

Comorbid Conditions



Note: Comorbids are confirmed during the clinical assessment; therefore comorbid conditions are only reported for high intensity members under management.

- In addition to managing the primary condition, Nurse Consultants identify comorbid conditions the member may have and individualize the member's management to address their various needs. The above graph lists the top 10 self-reported comorbid conditions for high intensity managed members.
- Nearly 62% of all high intensity managed members reported having at least one other comorbid condition. Across all comorbid conditions, hypertension is the most common, with 60% of high intensity members indicating they have hypertension, followed by 57% with high cholesterol. This is typical of most managed populations and expected since hypertension and high cholesterol are all associated with CAD and CHF.
- Diabetes, asthma and COPD are also listed in the top 10 list of frequently reported secondary conditions.
- In time, secondary conditions may begin to drive more utilization and dollars than the primary condition. It is critical to manage the entire person and not just the condition. HMC will continue to manage these high-risk individuals for both primary and secondary conditions.

Referrals

Referrals for Members Identified through 3/31/2005	Members[1] with Referrals	% of Total Referrals	% of Assessed Members[2]
Internal (within HMC)			
Pharmacist	327	30.1%	58.9%
Dietician	197	18.1%	35.5%
Behavioral Health Nurse	66	6.1%	11.9%
External			
Mental Health	233	21.4%	42.0%
Durable Medical Equipment	219	20.1%	39.5%
Home Health	24	2.2%	4.3%
Community Resources	11	1.0%	2.0%
Diabetes Education	4	0.4%	0.7%
Cardiac Rehab	3	0.3%	0.5%
Social Services	1	0.1%	0.2%
Nutritionist Consult	1	0.1%	0.2%
Physical Therapy	2	0.2%	0.4%
Total Referrals	1,088	100%	

[1] A case may have a referral in multiple categories.

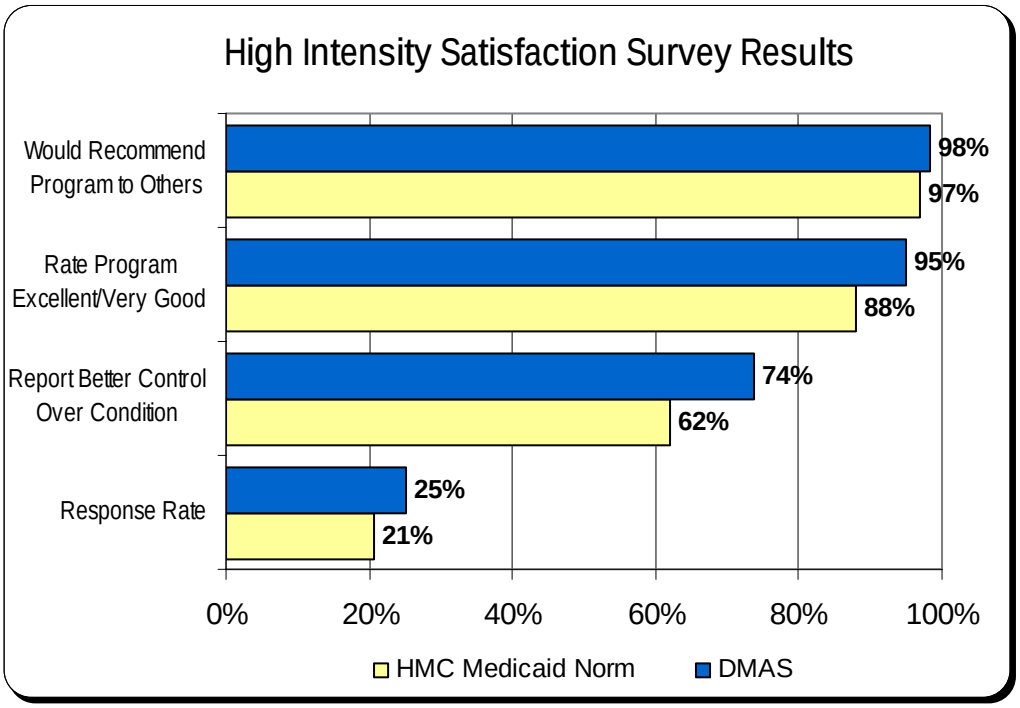
[2] High intensity assessed cases: n= 555

- Members may receive referrals to specialized resources as needed. Pharmacists, dieticians and behavioral health nurses are part of the internal Care Management team and are available for members consults. Referrals are also made to external resources available in the member's service area.
- Members were most frequently referred for consultations with a pharmacist. Routinely, pharmacy consults comprise the majority of referrals because members receive consultations related to their medications, ranging from necessity of the drug to daily dosage. These consultations frequently involve the member as well as the member's physician.
- Referrals for dieticians, mental health, behavioral health and durable medical equipment round out the top five.

Satisfaction Survey Results

The success of the program depends on constructive partnership with members. Participant satisfaction with the program is very high, as measured through satisfaction surveys. Surveys are sent annually to all high intensity members who remain active in the program.

- Surveys were mailed to 252 participants; 63 were returned for a response rate of 25%, above the average response rate for managed Medicaid populations (21%).
- DMAS participants responded more positively when compared to responses from the reference Medicaid population.
- 74% of satisfaction surveys respondents indicated that they had better control over their health/condition as a result of being in the program.
- 98% of the respondents would recommend the program to others.
- 95% of respondents rated the program as *excellen*t or *very good*, above the Medicaid norm (88%).



Program Initiatives and Strategies

Since program inception, HMC has specifically focused on improving the clinical outcomes for the Commonwealth of Virginia Department of Medical Assistance Services (DMAS) managed population. Through the strong partnership between HMC and DMAS, we have been successful in addressing the unique clinical needs of this population.

Numerous initiatives designed to deliver continued improvements in program outcomes have been implemented or are planned for the coming year, which is outlined below. HMC looks forward to the opportunity to implement our Disease Management (DM) services across all conditions and to your entire population. We plan on having continued collaboration ensuring optimal identification and execution of initiatives and other effective strategies focused on improving the health of DMAS members.

Improved Program Design and Delivery

Training

- Performed additional training for the engagement team to assist in engaging members.
- HMC Nurse Consultants began training on behavior modification techniques in September 2004 with Dr. Gary Rose of Harvard University. HMC nurse consultants continue to receive education and coaching through Virginia Commonwealth University.
- In order to have continuous improvement with our nurse staff, we have begun a Monthly Clinical Improvement Initiative campaigns in the first quarter of 2005, focusing on a different targeted outcome each month. The campaigns consist of educational information, designed around a barrier analysis conducted with the nurses. The educational information is focused on the following issues: 1) reinforcing the clinical outcome from a clinical perspective; 2) educational topics available to the members; 3) issues with meeting the targeted outcome; 4) ways to overcome resistance from the participants.
- Other components of the monthly Clinical Improvement Initiative campaign consist of an in-service to the nursing staff, targeted information in the weekly nurses newsletter, and information on the Clinical Improvement Initiative highlighted on the clinical storyboard for the month.

Data Enhancements

- Implementation of Non-Compliance Alerts in 2004. Members whose claims history show a lack of appropriate preventive tests receive quarterly reminders (letters) outlining the importance of testing and encouragement to see their physician. Beginning in July 2005, claims will be reviewed monthly and corresponding alerts issued to the member.

Additional Improvements

- Added behavioral health nurses to HMC staff, in October 2004, to deliver enhanced education on the importance of seeking treatment for depression.
- Each Nurse Consultant receives a cumulative monthly clinical report that shows how their participants are progressing towards achieving clinical guideline outcomes.

In addition to enhancing program design and delivery, HMC is committed to improving outcomes outlined in this report. Key methods used to improve outcomes in the high intensity population include:

For members with CAD, HMC will continue to:

- For CAD members with diabetes as a co-morbid, refer the participant to an HMC internal nutritional consultant and/or diabetic or nutritional education to obtain valuable information on glucose monitoring and diet instructions to impact the values for both A1C and LDL measures.

- Refer CAD members without diabetes to the HMC internal nutritional consultant to obtain valuable information on glucose monitoring and diet instructions to impact the values for both A1C and LDL measures.
- Increase the emphasis on blood pressure self-monitoring and assist the members in obtaining a blood reading through a community resource or help identify places the member can go for free monitoring. Continue to identify members on a monthly basis with either no values or high values and target those individuals for follow-up interventions.
- Continue to educate the member on the value of the annual lipid test as recommended by the program guidelines and work with the member and/or the provider in obtaining this important test.
- Provide education on the value of exercise, lipid control, diet, stress management, and medication compliance to maintain or decrease blood pressure values to guideline recommendations.
- For those members identified without a Beta Blocker or daily Aspirin therapy, the Pharmacy Consultant will outreach to physicians (telephonic or written) to encourage the use of appropriate medications in the management of the member's heart disease.

For members with CHF, HMC will continue to:

- Provide education on the importance of daily weights in the management of CHF and assist the member in obtaining a scale.
- Increase the emphasis on the adherence to a sodium-restricted diet and overcome the barriers to compliance.
- Provide education on the value of exercise, lipid control, diet, stress management, and medication compliance to maintain or decrease blood pressure values to guideline recommendations.
- For those members identified without an ACE Inhibitor or Beta Blocker medication, the Pharmacy Consultant will outreach to physicians (telephonic or written) to encourage the use of appropriate medications in the management of the member's congestive heart failure.

Continued Clinical Outcome Improvement

To improve clinical outcomes for Care Management members across all Disease Management clients, HMC clinical operations staff implemented a monthly clinical initiatives calendar of key topics to discuss with members (if appropriate) during scheduled intervention call.

2005 Monthly Clinical Initiatives:

January	A1C: Keeping A1C < 7%
February	PEF: Who provides PEF?; Who needs PEF?
March	Blood Pressure Control: Cause and Effect;
April	Lipid Testing and LDL values: Obtaining the test; impacting the values
May	Medication Compliance: Asthma – LTC; CAD/CHF – ACE and BB
June	Daily Weights: Importance of CHF management; Scales
July	Self Monitoring Blood Glucose
August	Asthma Action Plan / Diabetes Sick Day Plan
September	Sodium Restricted Diet
October	Dilated Retinal Eye Exam
November	Spirometry in COPD
December	Medication Compliance: Cardiac conditions

HMC looks forward to continued collaboration to provide superior program delivery to DMAS and its members. We are confident that the initiatives jointly developed and outlined in this section will improve overall clinical outcomes for the DMAS population through the next year.

Appendices

Methodology

HMC applied their standards savings methodology. The current methodology is a population-based analysis, structured to reduce regression to the mean and other biases that may inflate savings for disease management programs. The time periods analyzed are as follows:

Baseline: June 1, 2003 through March 31, 2004 with claims paid through June 30, 2004.
Year 1: June 1, 2004 through March 31, 2005 with claims paid through June 30, 2005.

Please note the time periods analyzed are 10-month periods rather than the usual 12 months. The time periods were shortened at the request of DMAS in order to provide program results within the requested timeframe.

IDENTIFIED POPULATION

- For claims analysis, individuals included in the report are based on cases identifiable within the specified time periods. For program activity, members identified since program inception are included.
- Certain cases are excluded from any analysis for specific reasons such as being Medical primary or where there is missing or inconsistent data that would skew results (these situations are specifically defined in HMC methodology documentation but are not outlined here due to the detail involved).

CLAIMS DATA

- Claims for identified members will be extracted from HMC's data warehouse. Claims may not match claims from Anthem Virginia for the same period because of duplicate claims, inability to match claims to other reports, etc.
- Only cases with six or more member months will be included in the claims analysis; this reflects a minimal enrollment criterion rather than a continuous enrollment criterion, which is in keeping with our current methodology.

Trends/Completion Factors

Baseline expense has been trend-adjusted to allow for meaningful comparison of results. Completion factors were not applied. Cost trends applied were based on the general population for Richmond Medicaid. Trends were supplied by Anthem Virginia Actuarial and agreed upon with DMAS. Utilization trends were not applied.

CLAIMS BASED OUTCOMES

Members are included for claims based clinical measures if they meet the prior criteria and have 10 member months with DMAS during the respective evaluation period. This is due to the fact that most clinical measures review adherence to yearly guidelines. Because the evaluation period was shortened from 12 to 10 months, the member month requirement for claims-based outcomes was reduced to 10 months.

SELF-REPORTED OUTCOMES

Results are compared for the first and last measure collected on the dynamic patient profile by the nurse consultants.

OTHER NOTES

- Member month data is approximated by HMC based on the monthly membership snapshots provided by Anthem Virginia.
- Certain claims are excluded from the analysis due to standard program claims exclusions.
- Testing for statistical significance was completed on all self-reported outcomes, SF-12 scores and average days lost, to determine if the change in outcome from first to last was significant. For self-reported clinical outcomes, the test applied was a two-tailed test with a 95% confidence interval. For SF-12 and average days lost, a two-tailed paired t-test was applied.
- Testing for statistical significance is not available for claims-based outcomes at this time. In a population-based study, the population in the current year may overlap with the population in the baseline. The two populations being compared are neither independent nor paired; therefore no straightforward statistical tests are appropriate to test the observed difference between the two populations. This issue needs further review by the DM industry.

Healthy Returns [sm] *Care Management* Program
DMAS - High Intensity Survey Results
All Conditions

n= 63 Response Rate:
d= 252 25.0%

1. I heard about the program through (Check all that apply):	Number	Percent
Telephone call from Program Nurse	45	71.4%
Benefits packet	5	7.9%
Home mailing describing program	15	23.8%
Doctor or doctor's office staff	2	3.2%
My spouse or friend	1	1.6%
Employer letter	0	0.0%
Other	4	6.3%

2. About how many times have you spoken with nurse?	Number	Percent
1 to 2 times	2	3.2%
3 to 6 times	7	11.1%
7 to 9 times	14	22.2%
10 to 12 times	18	28.6%
More than 12 times	20	31.7%

3. Please rate the program nurses on the following measures:

Knowledge of my health condition	Number	Percent
Excellent	42	67.7%
Very Good	15	24.2%
Good	2	3.2%
Fair	2	3.2%
Poor	1	1.6%
No Response	1	

Professionalism	Number	Percent
Excellent	40	76.9%
Very Good	11	21.2%
Good	0	0.0%
Fair	1	1.9%
Poor	0	0.0%
No Response	11	

Accessibility	Number	Percent
Excellent	38	73.1%
Very Good	11	21.2%
Good	2	3.8%
Fair	1	1.9%
Poor	0	0.0%
No Response	11	

4. Please rate the quality of the educational materials you received on the following measures:

Content of the materials	Number	Percent
Excellent	30	50.8%
Very Good	22	37.3%
Good	4	6.8%
Fair	3	5.1%
Poor	0	0.0%
No Response	4	

Ease of understanding the materials	Number	Percent
Excellent	29	58.0%
Very Good	18	36.0%
Good	1	2.0%
Fair	2	4.0%
Poor	0	0.0%
No Response	13	

Usefulness of the materials	Number	Percent
Excellent	30	60.0%
Very Good	16	32.0%
Good	2	4.0%
Fair	2	4.0%
Poor	0	0.0%
No Response	13	

5. If your experience with the program caused you to make any changes in your health management or status, check all that apply.

Accessibility	Number	Percent
Knowledge of my health condition	48	76.2%
Monitor my health condition more closely	52	82.5%
Proper use of my medications	28	44.4%
Change in my physical activity level/exercise	22	34.9%
Quit or reduced smoking	21	33.3%
Improved eating habits	33	52.4%
Weight management/weight loss	26	41.3%
Other	1	1.6%

6. Do you feel you now have better control over your health/condition as a result of being in the program?

	Number	Percent
Yes	45	73.8%
No	3	4.9%
Somewhat	12	19.7%
A little bit	1	1.6%
No Response	2	

7. How would you rate the program overall?

	Number	Percent
Excellent	43	71.7%
Very Good	14	23.3%
Good	2	3.3%
Fair	1	1.7%
Poor	0	0.0%
No Response	3	

8. Would you recommend the program to others?

	Number	Percent
Yes	60	98.4%
No	1	1.6%
No Response	2	

Glossary

Case: Member identified for management and assigned a primary condition (coronary artery disease, congestive heart failure, or diabetes) based on a review of medical and pharmacy claims data.

Case Status:

- Closed: Cases no longer under management, either by request or due to loss of eligibility.
- On Demand: Cases receiving mailings only (no outbound calls) and 24-hour access to program nurses, as needed. This is because either: 1) the disease management program was unable to establish contact or lost contact with the individual or 2) the individual decided against taking phone calls.
- Open: Cases under management, or in the process of being contacted. Because this is an opt-out program, all cases begin as Open and retain this status unless moved to Closed or On Demand.

Clinical Assessment: See Dynamic Patient Profile.

Comorbid Condition: Condition that is secondary to, and often related to, the primary condition (coronary artery disease, congestive heart failure, or diabetes). For example, an individual with diabetes may also have coronary artery disease and depression.

Dynamic Patient Profile (DPP): Tool based on established clinical practice guidelines that are used to classify a high intensity case's level of severity and control of condition. Results are used to establish level of adherence, define barriers to adherence, determine and evaluate progress towards goals.

Eligible Population: Individuals who, if identified as having one of the primary conditions, may participate in the disease management program because they are eligible based on client supplied membership data.

Engagement/Participation Rate: Measure of participation in the disease management program among the eligible identified cases. Defined as cases with a status of either 'On Demand' or 'Open' divided by all eligible cases.

HMC Medicaid Norm: Program normative value calculated by combining data for the Medicaid groups managed by HMC. The norm displayed is specific to HMC and does not represent any national norms.

High Intensity: Cases considered to be most likely to incur high levels of healthcare expenses in the future. They may be assigned either at the time of case creation or based on criteria evaluated by the care manager. High intensity cases receive regular follow-up calls, individualized plans of care based on their DPP results, 24-hour access to program nurses, and quarterly mailings of disease-specific information.

Identification and Stratification: Process to: 1) identify members with specified conditions using medical and pharmacy claims data and 2) classify them for the appropriate level of intervention (high or standard intensity), using predictive modeling.

Nurse Consultant: High intensity cases are assigned a Nurse Consultant who specializes in the care of the case's primary condition. The Nurse Consultant coordinates care through scheduled clinical assessments, development and evaluation of goals, condition-specific education, physician interaction, and referrals to additional ancillary services, as needed (e.g. pharmacist, physician specialist, dietitian or home health care). All Nurse Consultants are licensed registered nurses and maintain necessary licensure for any states in which their cases reside.

Predictive Model: Statistical approach to use information from past experiences and their relationships to predict future events. Predictive models that are developed for use with disease management programs enable the identification of individuals who are at greater risk for future adverse health events. This information is used to better allocate resources by stratifying identified cases into high or standard intensity management programs.

Prevalence/Identification Rate: Measure of the presence of a condition across the eligible population. Defined as the number of members identified with a primary condition divided by the eligible population.

Primary Condition: The principal condition for which a case is managed. Conditions are identified and assigned by a review of medical and pharmacy claims during the identification and stratification process. If a case is identified with multiple conditions, an algorithm - which considers the predicted risk of severity for each condition - is used to assign a primary condition.

Referral: High intensity members may receive referrals for specialized resources such as a pharmacist, physician specialist, dietitian or home health care agency.

SF-12 Assessment: Nationally recognized tool that measures self-perception of physical and mental health status. An initial SF-12 assessment is typically completed along with the initial DPP assessment and annually thereafter.

Standard Intensity: Cases considered at standard risk for future healthcare expenses, and who are able to manage their conditions with limited external support. They receive a mail-in assessment, educational materials, quarterly condition-specific information, and 24-hour access to program nurses. Cases initially stratified as standard may be later stratified to high intensity based upon the ongoing review of medical and pharmacy claims during the identification and stratification process.

Statistical Significance Testing: Significance testing was completed on all self-reported outcomes, SF-12 scores and average days lost, to determine if the change in outcome from first to last was significant.

- For self-reported clinical outcomes, the test applied was a two-tailed z-test with a 95% confidence interval. For SF-12 and average days lost, a two-tailed paired t-test was applied.

- Testing for statistical significance is not available for claims-based outcomes at this time. In a population-based study, the population in the current year partially overlaps with the population in the first year, i.e., some members are in both periods and some are not. The two populations being compared are neither independent nor paired. Therefore, no straightforward statistical tests are appropriate to test the observed difference between the two populations. This issue needs to be further reviewed and addressed by the DM industry.

Healthy Returns CAD Case Summary

Demographics:

This is a 60-year old female with the primary condition of coronary artery disease. The participant entered the Medicaid Healthy Returns Care Management Program on August 17, 2004. The participant has been in the Medicaid Healthy Returns Care Management Program for 14 months.

Status as of August 2004 at entry into program:

The participant was diagnosed with Class I coronary artery disease approximately five to ten years prior to enrollment into the Medicaid Healthy Returns Care Management Program. The participant was enrolled and received a comprehensive health assessment. The participant reported having the following comorbidities: hyperlipidemia, hypertension and gastro-esophageal reflux disease (GERD), arthritis and depression. The member reported having a triple coronary artery bypass graft (CABG) in 1999 and a cardiac catheterization with angioplasty and stent placement in 2004. The participant denied any hospitalizations related to her coronary artery disease since her bypass in 1999.

The participant reported having regular cardiology exams and annual lipid testing and was not able to recall her lipid results. The participant reported adherence with her prescribed medication regimen with lipotropics, coronary vasodilators, beta-blockers, ARB's, salicylates, anti-GERD medication and antidepressants. The participant reported non-compliance in following her physician's orders to monitor her blood pressure weekly due to not having a blood pressure cuff. The participant reported she was not exercising or following a specific diet plan because she did not have any orders from her physician. The participant admitted to smoking half-a-pack of cigarettes daily and does not drink alcohol. She reported having had a pneumonia vaccine in 2001 but was unable to receive an annual flu vaccine in 2004 due to the flu vaccine shortage.

Status improvements after 14 months of program management:

Following 14 months of management in the Medicaid Healthy Returns Care Management Program, the participant successfully completed annual lipid testing, received the flu vaccine in January of 2005 and achieved adherence in measuring her blood pressure daily in addition to following her diet and exercise plan as directed by her physician.

Process, Status and Clinical Improvements

- A functional health assessment (SF-12) is performed upon enrollment and yearly thereafter. The participant's Baseline emotional health score of 29.04 improved to 48.66. The participant's Baseline physical score of 30.04 decreased to 23.00 related to an increase in fatigue which is currently being addressed by her physician.
- Through comprehensive guideline education, goal setting and motivation, the participant was able to obtain a diet and exercise plan from her physician, flu vaccine and improve her blood pressure readings and lipid values.
- The NC educated the participant on the guidelines for coronary artery disease and instructed the member to obtain a low fat diet order from her physician The NC sent the participant written literature to reinforce the education and strategies for the management of CAD and hypertension, including the DASH diet plan.
- The Pharmacist educated the participant on the use of beta-blockers with depression. The participant reported that she feels her mental status is not affected by her medications.
- The participant indicated her readiness to quit smoking in March of 2005. The NC educated the member on the risks of smoking and the benefits of stopping for her condition and offered smoking cessation tips. The participant has since decreased smoking half a pack to two cigarettes daily.
- The participant acknowledged having annual lipid testing but was unaware of the results. The NC educated the participant on the importance of lipid testing and knowing the meaning of lipid values. Consequently, they developed a plan to gain better understanding and knowledge of her values. As a result of that intervention, she improved her lipid values and set a goal to maintain all lipid levels within the guideline recommendations.

- The participant confessed to having elevated blood pressure and that she did not monitor her blood pressure. The NC educated the participant on the importance of monitoring blood pressure and understanding the values in addition to the recommended target readings for coronary artery disease. The NC created a blood pressure cuff referral for the participant that was subsequently approved. The resulted in the participant's ability to successfully lower her blood pressure below the guideline target of < 140/90 for coronary artery disease. She currently remains adherent with measuring her blood pressure daily.

Preventative care activities, examination or evaluation:

1) Lipid testing- August 2005
   Cholesterol- decreased from 204 to 182 in August 2005 (AHA <200)
   LDL– decreased from 140 to 119 in August 2005 (AHA <100)
   HDL– decreased from 41 to 39 in August 2005 (AHA >50 females)
   Triglyceride – increased from 117 to 131 in August 2005 (AHA< 150)
2) Annual Cardiology Exam –August 2005- Easily fatigued and ejection fraction of 65%
3) Blood pressure – decreased from 147/68 to 117/43 in August 2005 (AHA < 140/90)

Complications of Risk

- In January 2005, the participant developed an ear infection and was successfully treated with antibiotics.
- In August of 2005, the participant reported seeing her physician for an increase in fatigue and underwent an echocardiogram and lab testing. She reported her blood glucose was elevated and that her ejection fraction was 65% during her last echocardiogram. The participant reported being told the circulation in her right leg was abnormal and that she will be scheduled for follow up blood work and an ultrasound of her right leg.

Education and Counseling Provided:

- Importance of having a yearly flu vaccine
- Written literature on the DASH diet plan and low sodium diets in maintaining a healthy diet
- The importance in monitoring her blood pressure
- Understanding blood pressure values and the recommended target for coronary artery disease
- Signs and symptoms of coronary artery disease and symptom management
- Meaning of lipid values and the importance of annual testing

Continued Care Management

- Nurse intervention calls will continue to focus on providing the needed guideline education and reinforcement on the importance of managing exacerbations and complications of coronary artery disease and hypertension. The NC will continue to encourage and reinforce the importance of maintaining her self-management care through annual lipid testing, annual flu vaccination and continued progress to complete smoking cessation.
- Nurse intervention calls will be directed at identifying strategies to assist the participant in stress management techniques related to her husband's declining health and unemployment status, and to achieve smoking cessation and lipid management.
- The Pharmacist will continue to review the member's medication regimen for optimal therapy and address any pharmaceutical alerts with the physician.

The member will be evaluated for graduation from the care management program once she achieves success in smoking cessation, demonstrates a stable trend with lipid and blood pressure results and consistently demonstrates self-management practices that align with the physician recommended plan of care and guideline recommendations.

Healthy Returns CHF Case Study

Demographics:

This is a 60-year old female with the primary condition of NYHC IV chronic heart failure, Class I coronary artery disease and type 2 diabetes. The participant entered the Medicaid Healthy Returns Care Management Program on June 25, 2004. The participant has been in the Medicaid Healthy Returns Care Management Program for 15 months.

Status as of August 2004 at entry into program:

The participant was diagnosed with NYHC IV chronic heart failure and Class I coronary artery disease more than 15 years ago and type 2 diabetes one to four years ago prior to enrollment into the Medicaid Healthy Returns Care Management Program. The participant was enrolled and received a comprehensive health assessment. The participant reported having the following co-morbidities: hyperlipidemia, hypertension and gastro-esophageal reflux disease (GERD), arthritis, breast cancer, Hodgkin's disease, depression, end-stage renal disease, thyroid disease, gout, atrial fibrillation, COPD, osteoporosis and sleep apnea. In addition to her co-morbid conditions, she reported having a myocardial infarction in 2001 followed by a stroke in 2002. The participant reported having a history of Hodgkin's disease which is currently in remission and a left kidney removal. The participant denied having any hospitalizations related to her chronic heart failure, coronary artery disease or diabetes since 2002.

The participant reported having regular cardiology exams and annual lipid testing being aware of only her cholesterol level of 150. The participant reported 100% adherence with her prescribed medication regimen. The participant reported adherence in following her physician's orders to monitor her blood pressure daily. The participant reported she was not exercising, performing daily weights or following a specific diet plan because she did not have any orders from her physician. The participant denied smoking tobacco products and does not drink alcohol. She reported having had a pneumonia vaccine in 1998 and the flu vaccine in November of 2003.

Status improvements after 15 months of program management:

Following 15 months of management in the Medicaid Healthy Returns Care Management Program, the participant successfully completed annual lipid testing and was aware of her results, obtained a flu vaccine in December of 2004 and maintained adherence in measuring her blood pressure daily. She was successful in obtaining a diet and exercise plan from her physician. The participant reported daily adherence to performing daily weight measurement in addition to following recommended diet and fluid restrictions. The participant reported obtaining a sick day plan for diabetes and completing urine microalbumin testing and a dilated eye exam. The participant reported having no need for a dental exam because she is edentulous and was unaware of any problem areas on her dentures that would cause potential complications.

Process, Status and Clinical Improvements

A functional health assessment (SF-12) is performed upon enrollment and yearly thereafter. The participant's Baseline mental health score of 43.70 improved to 56.56. The participant's physical score of 28.75 increased to 34.71.

- The NC educated the participant on the guidelines for chronic heart failure, coronary artery disease and diabetes. The NC mailed the participant written literature on multiple occasions to reinforce the education and strategies provided for the management of coronary artery disease, chronic heart failure, hypertension, atrial fibrillation, angina, arrhythmias, thyroid disorders, cancer, breast cancer, diabetes, the importance of exercise and low sodium diets and fluid restriction diets.
- The Pharmacist reviewed the participant's medication regimen for any alerts and guideline recommendations for her conditions.

- The Dietician reviewed the participant's case and educated her about foods and dietary modification that supported the control of her multiple conditions and disease processes. The Dietician noted participant had a positive attitude despite her many recommended dietary modifications and restrictions.
- The Nurse Consultant educated the participant on the importance of lipid testing and the importance of knowing her lipid values and their significance. She developed a plan for her to gain a better understanding of the values and the application to her daily self-management. Consequently, she is working to improve her lipid values and hopes to achieve and maintain lipid levels within the guideline recommendations.
- The participant was able to successfully maintain her blood pressure within the guideline target of < 130/80 for diabetes and remains adherent with measuring her blood pressure daily.

Preventative care activities, examination or evaluation:

1) Lipid testing- August 2005
   Cholesterol- increased from 150 to 183 in August 2005 (AHA <200)
   LDL– decreased from 103 to 52 in August 2005 (AHA <100)
   HDL– decreased from 59 to 51 in August 2005 (AHA >50 females)
   Triglyceride – increased from 68 to 109 in August 2005 (AHA< 150)
2) Annual Cardiology Exam –August 2005
3) Blood pressure – decreased from 147/68 to 117/43 in August 2005 (ADA < 130/80)
4) HgA1C- decreased from 5.3 % to 5.0 % in August of 2005
5) Annual urine microalbumin- No protein
6) Yearly dilated eye exam- No retinopathy
7) Blood pressure- 111/71 (ADA < 130/80)

Complications of Risk

- The participant has developed an infection of her Port-a-cath site from Hodgkin's disease multiple times throughout the year that has been successfully treated with antibiotics.
- The participant reported that on January 11, 2005 she had a re-insertion of a new Port-a-Cath. The EKG prior to the procedure showed a 'junctional rhythm and the cardiologist told her she may need to have a pacemaker insertion if her heart rhythm does not improve because her heart is beating to slow'.
- In April of 2005, the patient reported suffering a fracture of the right foot from osteoporosis. She currently continues to wear a supportive boot to assist in bone healing.
- On May 12, 2005, member underwent a bone scan confirming a fractured foot. Participant received bone stimulation treatments and wears a supportive boots. Participant claims reveal osteoporosis as a diagnosis. Participant reported to the Nurse Consultant that her foot fracture was related to diabetes.
- On May 15, 2005, the participant reported to the Nurse Consultant that she attended her scheduled appointment with her Cardiologist, Dr Welsh and was told that he could insert a pacemaker but was reluctant to proceed because of the history of her body rejecting the past three port-a-caths, resulting in infections. Per the participant, he stated "she was very complicated" and would rather wait as long as possible to insert a pacemaker.
- On July 29, 2005, participant underwent a Persantine stress test and experienced severe angina, nausea, vomiting and weakness.
- August 2005, the participant reported having surgery for a lumpectomy for suspicion of breast cancer and reported hemorrhaging from her wound when being discharged. The participant reported she was rushed back to the OR and was later given two units of packed cells. The participant said they fixed the problem but she did not recall what went wrong.
- The diagnosis post lumpectomy was breast cancer and the participant underwent a mastectomy on August 30, 2005. She reported she was informed she was not a candidate for chemotherapy or radiation related to her end stage renal disease.

Education and Counseling Provided

- Importance of having a yearly flu vaccine
- Written literature on chronic heart failure, coronary artery disease, diabetes, cancer, thyroid disease, angina, atrial fibrillation, cardiac arrhythmias and pacemaker insertions.
- The signs and symptoms of hyperglycemia and hypoglycemia with appropriate management interventions
- Signs and symptoms of coronary artery disease with appropriate management
- Signs and symptoms of a heart attack
- Nitroglycerin administration when experiencing chest pain
- Managing diet, medications and activity when taking Anti-Coagulants

Continued Care Management

- Nurse Consultant intervention calls will continue and focus on reinforcing previous education on the importance of managing exacerbations and complications of chronic heart failure, coronary artery disease, hypertension, hyperglycemia and hypoglycemia. Education will reinforce the importance of continuing annual lipid testing, the annual flu vaccination and dietary adherence.
- The Nurse Consultant will educate the participant on the signs and symptoms of a systemic infection and wound infections related to her recent lumpectomy, mastectomy and history of previous systemic infections secondary to Port-a-Cath rejection and infection.
- Nurse Consultant intervention calls will continue to assess her mental health status related to her new diagnosis of breast cancer and multiple chronic illnesses.
- The Nurse Consultant will assess the need to create a referral for home health if the participant demonstrates a need for further assessment and intervention related to her recent mastectomy, chronic illness, history of wound infections and pain control.
- Pharmacists will continue to review the member's medication regimen for optimal therapy of all disease processes and address any pharmaceutical alerts with the physician.
- The Nurse Consultant will create a referral for an internal Dietician to contact member for education regarding her new diagnosis of breast cancer to assist the participant on healthy food selections to promote wound healing and immunosuppression.

The member will be evaluated for graduation from the care management program once she demonstrates no cardiac exacerbations, a stable trend with lipid management, blood pressure readings, and consistently demonstrates self-management practices that align with her physician's recommended plan of care and guideline recommendations.

Overall Clinical Outcomes Table

Primary Goals and Outcomes Measures
Baseline versus Year 1

Condition/Measure	Review Period	Number Reviewed[1]	Number Achieving Goal	Percent Achieving Goal	Percent Change From BL/First	Goal (Percent Achieving Goal)	Goal Source[3]	Data Source[2]
CAD								
Beta blockers	BL	1592	846	53%		>85%	HMC	Claims
	Year 1	1741	951	55%	3%			
Daily ASA or Anti-Platelet Therapy*	First	206	132	64%		>80%	HMC	DPP
	Last	206	173	84%	31%			
	All	283	278	98%				
Annual LDL Test	BL	1592	255	16%		>75%	NCQA	Claims
	Year 1	1741	308	18%	10%			
Blood pressure controlled (<=140/90)	First	151	109	72%		>60%	HP2010	DPP
(member who provided values,	Last	151	115	76%	6%			
excludes unknown responses)	All	250	192	77%				
LDL<100	First	32	27	84%		>85%	NCQA	DPP
(member who provided values,	Last	32	30	94%	11%			
excludes unknown responses)	All	129	72	56%				
CAD w/comorbid of diabetes A1C < 7	First	27	14	52%		>70%	NCQA/ADA	DPP
(member who provided values,	Last	27	12	44%	-14%			
excludes unknown responses)	All	71	36	51%				
CHF								
ACE Inhibitors	BL	1257	838	67%		>70%	HMC	Claims
	Year 1	1040	673	65%	(3%)			
Beta Blockers	BL	1257	633	50%		>70%	HMC	DPP/Claims
	Year 1	1040	511	49%	(2%)			
Annual LDL Test	BL	1257	143	11%		>75%	NCQA/ADA	Claims
	Year 1	1040	142	14%	20%			
Monitor daily weight*	First	105	13	12%		>70%	AHA	DPP
(NYHA Class II-IV)	Last	105	46	44%	254%			
	All	160	57	36%				
Adhering to sodium restricted diet	First	91	83	91%		>80%	FACCT	DPP
(doctor ordered diet)	Last	91	87	96%	5%			
	All	161	148	92%				
Blood pressure controlled (<=130/85)	First	95	43	45%		>60%	HP2010	DPP
(member who provided values,	Last	95	54	57%	26%			
excludes unknown responses)	All	160	93	58%				

[1] Number responding/reviewed: For self-reported measures on the Dynamic Patient Profile (DPP), the number responding includes members who completed two assessments, at least 30 days apart. The last assessment must have occurred after 6/1/2004. For claims-based measures, the number reviewed includes members with the condition who have been enrolled with DMAS for 10 member months during the evaluation period.

[2] Data Source:
DPP = Dynamic Patient Profile (self-reported information)
Claims = Medical and/or Pharmacy claims data
DPP/Claims = Outcomes based on claims data, but severity level from self-reported DPP

[3] Goal Source:
ADA = American Diabetes Association
AHA = American Heart Association
FACCT = Foundation for Accountability
HMC = Health Management Corporation
HP2010 = Healthy People 2010
NCQA = National Committee for Quality Assurance
NIH = National Institutes of Health
SF-12 = Health status survey, QualityMetric, Inc.

*Indicates change for self-reported measure is statistically significant at the 0.05 level using a two-tailed test.

Table 1: All Settings by Diagnosis Description (ranked by expense PDMPM)

ICD-9 Diagnoses Group Description	Utilization/100DMM			Expense PDMPM			
	Baseline	Year 1	% CHG	Baseline Trended	Year 1	Change	% CHG
Ischemic heart disease	274.97	308.73	12%	$ 97.45	$ 99.13	$ 1.68	2%
Other forms of heart disease	341.84	388.81	14%	$ 81.67	$ 74.28	$ (7.39)	-9%
Symptoms	708.97	893.11	26%	$ 80.77	$ 93.32	$ 12.55	16%
Cerebrovascular disease	52.99	57.10	8%	$ 55.58	$ 17.00	$ (38.57)	-69%
Chronic obstructive pulmonary disease and allied conditions	257.48	361.11	40%	$ 45.51	$ 47.93	$ 2.42	5%
Other psychoses	134.74	185.83	38%	$ 26.98	$ 33.93	$ 6.95	26%
Diseases of other endocrine glands	376.78	503.94	34%	$ 24.68	$ 28.41	$ 3.73	15%
Pneumonia and influenza	59.61	77.61	30%	$ 24.06	$ 20.56	$ (3.50)	-15%
Other diseases of respiratory system	88.93	121.64	37%	$ 18.47	$ 28.05	$ 9.58	52%
Other diseases of digestive system	53.47	61.27	15%	$ 17.86	$ 17.86	$ 0.00	0%
Congenital anomalies	38.16	11.58	-70%	$ 15.89	$ 0.78	$ (15.11)	-95%
Arthropathies and related disorders	138.53	153.11	11%	$ 15.89	$ 17.43	$ 1.54	10%
Persons encountering health services for specific procedures and aftercare	48.51	82.05	69%	$ 15.84	$ 20.96	$ 5.12	32%
Diseases of arteries, arterioles, and capillaries	29.89	29.71	-1%	$ 14.10	$ 11.95	$ (2.15)	-15%
Hypertensive disease	157.37	186.23	18%	$ 14.08	$ 12.60	$ (1.48)	-11%
Diseases of the blood and blood-forming organs	139.23	184.53	33%	$ 11.89	$ 20.06	$ 8.17	69%
Other bacterial diseases	14.31	19.39	35%	$ 11.74	$ 10.33	$ (1.41)	-12%
Mycoses	7.61	7.90	4%	$ 11.10	$ 2.27	$ (8.82)	-80%
Diseases of esophagus, stomach, and duodenum	47.64	56.06	18%	$ 10.69	$ 11.60	$ 0.91	9%
Other metabolic and immunity disorders	94.41	134.26	42%	$ 9.98	$ 11.92	$ 1.94	19%
Dorsopathies	107.29	159.12	48%	$ 9.56	$ 15.60	$ 6.04	63%
Other diseases of urinary system	56.34	73.97	31%	$ 7.47	$ 8.11	$ 0.64	9%
Disorders of the eye and adnexa	70.00	95.83	37%	$ 7.44	$ 10.35	$ 2.91	39%
Pneumoconioses and other lung diseases due to external agents	4.31	5.25	22%	$ 6.86	$ 1.30	$ (5.56)	-81%
Nephritis, nephrotic syndrome, and nephrosis	49.95	43.36	-13%	$ 6.21	$ 6.98	$ 0.77	12%
Top 25	**3353.35**	**4201.53**	**25%**	**$ 641.77**	**$ 622.71**	**$ (19.06)**	**-3%**

Table 2: Top 25 NDC Drug Classes (ranked by expense PDMPM)

ICD-9 Diagnoses Group Description	Utilization/100DMM			Expense PDMPM			
	Baseline	Year 1	% CHG	Baseline Trended	Year 1	Change	% CHG
gastric acid secretion reducers	515.18	521.04	1%	$ 53.83	$ 46.89	$ (6.94)	-13%
lipotropics	524.67	589.81	12%	$ 42.97	$ 52.09	$ 9.12	21%
analgesics,narcotics	599.11	619.57	3%	$ 26.96	$ 27.58	$ 0.62	2%
anticonvulsants	232.94	255.63	10%	$ 20.23	$ 23.06	$ 2.83	14%
antipsychotics,atypical,dopamine,& serotonin antag	84.23	89.64	6%	$ 18.12	$ 17.69	$ (0.44)	-2%
nsaids, cyclooxygenase inhibitor - type	218.50	179.32	-18%	$ 16.48	$ 11.27	$ (5.21)	-32%
selective serotonin reuptake inhibitor (ssris)	224.20	235.92	5%	$ 16.08	$ 15.29	$ (0.79)	-5%
platelet aggregation inhibitors	147.28	165.00	12%	$ 14.47	$ 16.50	$ 2.03	14%
calcium channel blocking agents	269.58	268.65	0%	$ 11.97	$ 11.31	$ (0.66)	-5%
hypoglycemics, insulin-response enhancer (n-s)	99.94	107.68	8%	$ 11.67	$ 12.43	$ 0.77	7%
beta-adrenergic agents	237.82	242.21	2%	$ 10.98	$ 11.41	$ 0.43	4%
insulins	166.51	160.34	-4%	$ 10.95	$ 11.68	$ 0.73	7%
hypotensives, ace inhibitors	362.86	349.85	-4%	$ 10.16	$ 6.56	$ (3.60)	-35%
inotropic drugs	2.31	1.57	-32%	$ 8.81	$ 4.53	$ (4.28)	-49%
pulmonary antihypertensives, prostacyclin-type	2.52	1.71	-32%	$ 8.65	$ 7.72	$ (0.93)	-11%
hypotensives,angiotensin receptor antagonist	166.59	187.13	12%	$ 7.98	$ 8.82	$ 0.84	11%
quinolones	85.93	76.17	-11%	$ 6.34	$ 4.21	$ (2.13)	-34%
antihistamines - 2nd generation	128.65	112.22	-13%	$ 6.25	$ 2.38	$ (3.87)	-62%
beta-adrenergics and glucocorticoids combination	45.25	61.90	37%	$ 6.15	$ 8.32	$ 2.18	35%
leukotriene receptor antagonists	78.18	84.12	8%	$ 5.73	$ 6.15	$ 0.42	7%
hypoglycemics, biguanide type (non-sulfonylureas)	113.99	114.06	0%	$ 5.59	$ 3.36	$ (2.23)	-40%
beta-adrenergic blocking agents	379.61	382.70	1%	$ 5.35	$ 3.00	$ (2.35)	-44%
hypoglycemics, insulin-release stimulant type	159.94	166.35	4%	$ 5.35	$ 4.80	$ (0.55)	-10%
anti-anxiety drugs	285.33	302.58	6%	$ 5.33	$ 4.93	$ (0.40)	-8%
vasodilators,coronary	223.50	221.87	-1%	$ 5.16	$ 4.62	$ (0.54)	-11%
Top 25	**5354.60**	**5497.04**	**3%**	**$ 153.92**	**$ 142.09**	**$ (11.82)**	**-8%**

Table 3: Condition Savings by Setting - Condition-related and Non Condition-related

CAD - Condition Related					CAD - Non Condition Related				CAD - Total			
Setting	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM
IP	BL	$ 1,020,742.87	$ 65.68		BL	$ 3,853,191.70	$ 247.92		BL	$ 4,873,934.57	$ 313.60	
	Y1	$ 1,564,408.00	$ 93.24	$ 27.56	Y1	$ 3,602,588.57	$ 214.71	$ (33.21)	Y1	$ 5,166,996.57	$ 307.94	$ (5.65)
IP Prof	BL	$ 106,493.60	$ 6.85		BL	$ 310,395.87	$ 18.50		BL	$ 416,889.48	$ 24.85	
	Y1	$ 181,932.00	$ 10.84	$ 3.99	Y1	$ 496,636.55	$ 29.60	$ 11.10	Y1	$ 678,568.55	$ 40.44	$ 15.60
OP Fac	BL	$ 232,939.75	$ 14.99		BL	$ 1,517,043.99	$ 97.61		BL	$ 1,749,983.74	$ 112.60	
	Y1	$ 252,987.35	$ 15.08	$ 0.09	Y1	$ 1,572,509.81	$ 93.72	$ (3.89)	Y1	$ 1,825,497.16	$ 108.80	$ (3.80)
OP Prof	BL	$ 138,369.41	$ 8.90		BL	$ 1,251,135.49	$ 80.50		BL	$ 1,389,504.90	$ 89.40	
	Y1	$ 157,416.00	$ 9.38	$ 0.48	Y1	$ 1,874,578.97	$ 111.72	$ 31.22	Y1	$ 2,031,994.97	$ 121.10	$ 31.70
Other	BL	$ 10,904.00	$ 0.70		BL	$ 426,518.63	$ 27.44		BL	$ 437,422.63	$ 28.14	
	Y1	$ 24,010.00	$ 1.43	$ 0.73	Y1	$ 787,068.98	$ 46.91	$ 19.47	Y1	$ 811,078.98	$ 48.34	$ 20.19
Pharm	BL	$ 919,883.78	$ 59.19		BL	$ 6,134,337.24	$ 394.69		BL	$ 7,054,221.02	$ 453.88	
	Y1	$ 901,738.66	$ 53.74	$ (5.44)	Y1	$ 6,550,123.06	$ 390.38	$ (4.32)	Y1	$ 7,451,861.72	$ 444.12	$ (9.76)
Total	BL	$ 2,429,333.41	$ 156.31		BL	$ 13,492,622.92	$ 868.14		BL	$ 15,921,956.33	$ 1,024.45	
	Y1	$ 3,082,492.01	$ 183.71	$ 27.40	Y1	$ 14,883,505.94	$ 887.03	$ 18.89	Y1	$ 17,965,997.95	$ 1,070.74	$ 46.30

Member Months		
	BL	15,542
	Y1	16,779

Note: Positive savings are indicated by parentheses

CHF - Condition Related					CHF- Non Condition Related				CHF - Total				
Setting	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM
IP	BL	$ 1,853,579.96	$ 153.96		IP BL	$ 4,898,925.99	$ 406.92		IP BL	$ 6,752,505.95	$ 560.89	
	Y1	$ 1,573,557.00	$ 158.07	$ 4.10	Y1	$ 3,332,774.27	$ 334.78	$ (72.14)	Y1	$ 4,906,331.27	$ 492.85	$ (68.03)
IP Prof	BL	$ 175,339.79	$ 14.56		IP Prof BL	$ 603,664.98	$ 50.14		IP Prof BL	$ 779,004.77	$ 64.71	
	Y1	$ 116,382.00	$ 11.69	$ (2.87)	Y1	$ 532,518.66	$ 53.49	$ 3.35	Y1	$ 648,900.66	$ 65.18	$ 0.48
OP Fac	BL	$ 206,366.89	$ 17.14		OP Fac BL	$ 1,587,949.93	$ 131.90		OP Fac BL	$ 1,794,316.82	$ 149.04	
	Y1	$ 147,292.85	$ 14.80	$ (2.35)	Y1	$ 1,159,002.78	$ 116.42	$ (15.48)	Y1	$ 1,306,295.63	$ 131.22	$ (17.82)
OP Prof	BL	$ 119,684.35	$ 9.94		OP Prof BL	$ 1,243,887.33	$ 103.32		OP Prof BL	$ 1,363,571.67	$ 113.26	
	Y1	$ 77,646.00	$ 7.80	$ (2.14)	Y1	$ 1,290,257.10	$ 129.61	$ 26.29	Y1	$ 1,367,903.10	$ 137.41	$ 24.15
Other	BL	$ 128,921.00	$ 10.71		Other BL	$ 778,928.22	$ 64.70		Other BL	$ 907,849.22	$ 75.41	
	Y1	$ 130,207.00	$ 13.08	$ 2.37	Y1	$ 913,467.08	$ 91.76	$ 27.06	Y1	$ 1,043,674.08	$ 104.84	$ 29.43
Pharm	BL	$ 899,694.57	$ 74.73		Pharm BL	$ 5,889,068.82	$ 489.17		Pharm BL	$ 6,788,763.38	$ 563.90	
	Y1	$ 606,126.12	$ 60.89	$ (13.85)	Y1	$ 4,897,083.43	$ 491.92	$ 2.76	Y1	$ 5,503,209.55	$ 552.81	$ (11.09)
Total	BL	$ 3,383,586.56	$ 281.05		Total BL	$ 15,002,425.26	$ 1,246.15		Total BL	$ 18,386,011.81	$ 1,527.20	
	Y1	$ 2,651,210.97	$ 266.32	$ (14.73)	Y1	$ 12,125,103.32	$ 1,217.99	$ (28.16)	Y1	$ 14,776,314.29	$ 1,484.31	$ (42.89)

Member Months		
	BL	12,039
	Y1	9,955

Note: Positive savings are indicated by parentheses

All - Condition Related					All - Non Condition Related				All - Total			
Setting	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM	Time	Costs(trended to latest year)	Total Cost PDMPM	Savings PDMPM
IP	BL	$ 2,874,322.83	$ 104.21		IP BL	$ 8,752,117.69	$ 317.32		IP BL	$ 11,626,440.52	$ 421.54	
	Y1	$ 3,137,965.00	$ 117.38	$ 13.16	Y1	$ 6,935,362.84	$ 259.42	$ (57.90)	Y1	$ 10,073,327.84	$ 376.80	$ (44.74)
IP Prof	BL	$ 281,833.40	$ 10.22		IP Prof BL	$ 914,060.85	$ 33.14		IP Prof BL	$ 1,195,894.25	$ 43.36	
	Y1	$ 298,314.00	$ 11.16	$ 0.94	Y1	$ 1,029,155.21	$ 38.50	$ 5.36	Y1	$ 1,327,469.21	$ 49.65	$ 6.30
OP Fac	BL	$ 439,306.65	$ 15.93		OP Fac BL	$ 3,104,993.92	$ 112.58		OP Fac BL	$ 3,544,300.56	$ 128.51	
	Y1	$ 400,280.20	$ 14.97	$ (0.96)	Y1	$ 2,731,512.59	$ 102.17	$ (10.40)	Y1	$ 3,131,792.79	$ 117.15	$ (11.36)
OP Prof	BL	$ 258,053.75	$ 9.36		OP Prof BL	$ 2,495,022.82	$ 90.46		OP Prof BL	$ 2,753,076.57	$ 99.82	
	Y1	$ 235,062.00	$ 8.79	$ (0.56)	Y1	$ 3,164,836.07	$ 118.38	$ 27.92	Y1	$ 3,399,898.07	$ 127.18	$ 27.36
Other	BL	$ 139,825.00	$ 5.07		Other BL	$ 1,205,446.85	$ 43.71		Other BL	$ 1,345,271.85	$ 48.78	
	Y1	$ 154,217.00	$ 5.77	$ 0.70	Y1	$ 1,700,536.06	$ 63.61	$ 19.90	Y1	$ 1,854,753.06	$ 69.38	$ 20.60
Pharm	BL	$ 1,819,578.34	$ 65.97		Pharm BL	$ 12,023,406.06	$ 435.93		Pharm BL	$ 13,842,984.40	$ 501.90	
	Y1	$ 1,507,864.78	$ 56.40	$ (9.57)	Y1	$ 11,447,206.49	$ 428.19	$ (7.74)	Y1	$ 12,955,071.27	$ 484.59	$ (17.31)
Total	BL	$ 5,812,919.97	$ 210.76		Total BL	$ 28,495,048.18	$ 1,033.14		Total BL	$ 34,307,968.15	$ 1,243.90	
	Y1	$ 5,733,702.98	$ 214.47	$ 3.71	Y1 Y1	$ 27,008,609.26	$ 1,010.27	$ (22.87)	Y1	$ 32,742,312.24	$ 1,224.74	$ (19.15)

Member Months	BL	27,581
	Y1	26,734

Note: Positive savings are indicated by parentheses

Table 4: Condition Utilization by Setting - Condition-related and Non Condition-related

	CAD - Condition Related				CAD - Non Condition Related				CAD - Total			
	Time	Units / 1000	Change from Y2	% Change from Y2	Time	Units / 1000	Change from Y2	% Change from Y2	Time	Units / 1000	Change from Y2	% Change from Y2
IP Admits	BL	111.2			IP Admits BL	438.6			IP Admits BL	549.7		
	Y1	135.2	24.0	22%	Y1	453.4	14.9	3%	Y1	588.6	38.9	7%
IP Prof	BL	35.5			IP Prof BL	519.7			IP Prof BL	555.2		
	Y1	59.4	23.8	67%	Y1	855.0	335.3	65%	Y1	914.4	359.1	65%
OP Fac Visits	BL	112.0			OP Fac Visits BL	2,805.8			OP Fac Visits BL	2,917.8		
	Y1	146.6	34.7	31%	Y1	3,067.4	261.6	9%	Y1	3,214.0	296.2	10%
OP Prof Visits	BL	98.6			OP Prof Visits BL	1,951.1			OP Prof Visits BL	2,049.7		
	Y1	116.1	17.5	18%	Y1	2,530.5	579.4	30%	Y1	2,646.6	596.9	29%
Pharm	BL	1,780.2			Pharm BL	6,516.0			Pharm BL	8,296.2		
	Y1	1,793.7	13.4	1%	Y1	6,886.7	370.7	6%	Y1	8,680.4	384.1	5%
									Member Months BL	15,542		
									Y1	16,779		

	CHF - Condition Related				CHF - Non Condition Related				CHF - Total			
	Time	Units / 1000	Change from Y2	% Change from Y2	Time	Units / 1000	Change from Y2	% Change from Y2	Time	Units / 1000	Change from Y2	% Change from Y2
IP Admits	BL	272.1			IP Admits BL	740.6			IP Admits BL	1,012.7		
	Y1	207.3	-64.8	-24%	Y1	720.8	-19.7	-3%	Y1	928.2	-84.5	-8%
IP Days	BL	1,558.9			IP Days BL	4,571.1			IP Days BL	6,130.1		
	Y1	1,301.9	-257.1	-16%	Y1	4,098.4	-472.7	-10%	Y1	5,400.3	-729.8	-12%
OP Fac Visits	BL	323.0			OP Fac Visits BL	3,318.2			OP Fac Visits BL	3,641.2		
	Y1	297.7	-25.2	-8%	Y1	3,388.4	70.2	2%	Y1	3,686.2	45.0	1%
OP Prof Visits	BL	129.8			OP Prof Visits BL	2,295.0			OP Prof Visits BL	2,424.8		
	Y1	122.2	-7.5	-6%	Y1	2,741.0	446.0	19%	Y1	2,863.2	438.4	18%
Pharm	BL	2,354.2			Pharm BL	7,501.8			Pharm BL	9,856.1		
	Y1	2,132.4	-221.9	-9%	Y1	7,956.0	454.2	6%	Y1	10,088.4	232.4	2%
									Member BL	12,039		
									Y1	9,955		

	All - Condition Related				All - Non Condition Related				All - Total			
	Time	Units / 1000	Change from Y2	% Change from Y2	Time	Units / 1000	Change from Y2	% Change from Y2	Time	Units / 1000	Change from Y2	% Change from Y2
IP Admits	BL	181.4			IP Admits BL	570.4			IP Admits BL	751.8		
	Y1	162.0	-19.4	-11%	Y1	553.0	-17.4	-3%	Y1	715.0	-36.8	-5%
IP Days	BL	911.5			IP Days BL	3,303.1			IP Days BL	4,214.6		
	Y1	863.2	-48.3	-5%	Y1	2,901.5	-401.7	-12%	Y1	3,764.6	-450.0	-11%
OP Fac Visits	BL	204.1			OP Fac Visits BL	3,029.5			OP Fac Visits BL	3,233.5		
	Y1	202.9	-1.2	-1%	Y1	3,187.0	157.5	5%	Y1	3,389.8	156.3	5%
OP Prof Visits	BL	112.2			OP Prof Visits BL	2,101.2			OP Prof Visits BL	2,213.4		
	Y1	118.4	6.2	5%	Y1	2,608.9	507.7	24%	Y1	2,727.3	513.8	23%
Pharm	BL	2,030.8			Pharm BL	6,946.3			Pharm BL	8,977.1		
	Y1	1,919.8	-111.0	-5%	Y1	7,284.9	338.6	5%	Y1	9,204.7	227.6	3%
									Member BL	27,581		
									Y1	26,734		